EXHIBIT B

In The Matter of:

REESE, ET AL.

vs.

CNH GLOBAL N.V. and CNH AMERICA,LLC

SUZANNE DANIELS, PH.D.

January 10, 2014

MERRILL LAD
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Phone: 800.292.4789 Fax:202.861.3425

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

JACK REESE, FRANCES ELAINE PIDDE, JAMES CICHANOFSKY, ROGER MILLER, and GEORGE NOWLIN,

Plaintiffs,

vs. Case No. 2:04-cv-70592-PJD-PJK

Hon. Patrick J. Duggan, U.S.D.J.

Hon. Paul J. Komives, U.S. Mag. J.

CNH GLOBAL N.V. and CNH AMERICA LLC,

Defendants.

The Deposition of SUZANNE MARIE DANIELS, Ph.D.

Taken at 400 Galleria Officentre, Suite 117

Southfield, Michigan

Commencing at 9:28 a.m.

Friday, January 10, 2014

Before Mary Jo Power, CSR-1404, RPR, RMR, CRR

APPEARANCES:

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TABLE OF CONTENTS

Page 6

Southfield, Michigan
Friday, January 10, 2014
9:28 a.m.

SUZANNE MARIE DANIELS, Ph.D.,
was thereupon called as a witness herein, and after having first been duly sworn to testify to the truth, the whole truth and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. BURCHFIELD:

Q. Would you please state your full name for the record.
A. Suzanne Marie Daniels.
Q. And you're a Ph.D. in economics; is that correct?
A. Yes.
Q. And could you give us just an overview of your educational background: undergraduate degree, and graduate degrees, please.
A. My undergraduate degree is in economics, bachelors; and I have a Ph.D. in economics.
Q. From what institutions?
A. From Wayne State University, both degrees.
Q. And what were the dates of those degrees?
A. They are stated on my bio with my report.
Q. Okay. We'll get to that in short order.

Page 7

Ms. Daniels, let me ask the reporter to mark as Daniels Exhibits 1 and 2 a -- two subpoenas that I believe were served on you.
This will be number 1, copy for Counsel; and this will be number 2.
MARKED BY THE REPORTER:
DEPOSITION EXHIBITS 1 and 2
9:29 a.m.

BY MR. BURCHFIELD:

Q. Dr. Daniels, I'm handing to you Daniels Exhibit 1, which is a subpoena duces tecum dated December 13, 2013, and would you take a moment and let me know if you've seen that document before.
A. Yes, I have seen this document before.
Q. You have. Okay.
And Daniels Exhibit 2 is a subpoena duces tecum dated December 30, 2013, which has a supplemental document request at the end. And take a moment, let me know if you've seen that one before.
A. Yes, I've seen this document.
Q. Now, do you have any -- you're obviously appearing for the deposition here in person today, and we'll ask questions, but do you have any documents responsive to these subpoenas to produce today?
MR. CANZANO: I'm going to interject or object here in that the time for the return of these subpoenas has not yet occurred. We will be filing a -- and I believe we either have or will be today serving an objection to the December 30 subpoena.
The other one I don't want to say for certain, because Darcie was handling this part of it, but I believe that the response to that is essentially that there are no further documents, you have the rebuttal report, and the only other things that would be -- that she relied on would be the documents mentioned in there which came from you and are in your expert's report.

Page 8

MR. BURCHFIELD: Okay.
MR. CANZANO: But the December 30 one regarding the mission -- I'll call that the mission subpoena -- we are objecting to that.
MR. BURCHFIELD: Okay. Well, let me just ask you: Do you intend -- do the plaintiffs intend to withdraw the like subpoena that has been served on Mr. Macey?
MR. CANZANO: I don't believe so.

BY MR. BURCHFIELD:

Q. Okay. Ms. Daniels, let's set aside Exhibit -- well, Exhibit 2, let's look at the document request on that, and this is the document request that Counsel referred to as the mission request. I think that's as fair a consideration, without reading the whole thing, as any.
You, just to be clear, you are not today producing and have not produced any documents in response to the document request at the end of Exhibit 2; is that correct?
A. They're not due yet till the 15th.
Q. But do you intend to produce any documents in response to it?
MR. CANZANO: We're objecting, so there won't be any documents produced.

Page 9

BY MR. BURCHFIELD:

Q. All right. And that's your understanding as well?
A. That's my understanding.
Q. That's all I wanted to confirm for the record.
Now with regard to Exhibit 1, the document request appended to the December 13 subpoena which begins with the document request your rebuttal expert report, is it your understanding, Dr. Daniels, that all documents responsive to this request have been already produced to us?
A. That is correct, because the documents were those that were provided by the defense. Mr. Macey's report and the references in his report is what I relied on.

Q. Okay. Thank you.
MR. BURCHFIELD: Let me ask the reporter to mark as Daniels Exhibit 3 a document entitled SNG Consulting, LLC, Consulting Agreement.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 3
9:34 a.m.
MR. BURCHFIELD: Thank you.
BY MR. BURCHFIELD:
Q. Dr. Daniels, I'm handing you Exhibit 3. Do you recognize this document?
A. I do, yes.
Q. Is this the -- is this the consulting agreement that relates to the services you have provided in this case of Reese versus CNH?
A. Yes, it does. Yes.
Q. And just to confirm, under the heading Charges and Payments, your rate for consulting services is $200 an hour?
A. Yes.
Q. And your rate is $350 an hour for depositions, that would be today; deposition preparation and travel time; court, arbitration, mediation appearances; and court, arbitration, mediation appearances, preparation, and travel time; is that correct?

A. Yes.
Q. Okay. And this document was signed by you on page 3, it looks like on May 29, 2013, correct?
A. Yes.
Q. And is this agreement -- does this follow a form that you use in your consulting business, or was this a form that was provided to you by the McKnight Law Firm?
A. This is my standard consulting agreement.
Q. Okay. And I notice, by the way, Dr. Daniels, in your consulting agreement on page 3 there's a waiver of jury trial; do you see that?
A. Yes.
Q. And what's the -- what, if you know, is the reason that you have a waiver of jury trial in your standard consulting agreement?
A. I'd have to discuss that with Counsel.
MR. BURCHFIELD: Let me ask the reporter to mark three documents -- actually, there may be four documents here, the first of which would be Daniels Exhibit 4 is entitled Declaration of Suzanne M. Daniels.
Let me go ahead and mark all these.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 4

9:38 a.m.
MR. BURCHFIELD: Daniels Exhibit 5 is a preliminary expert report of Suzanne Daniels dated June 3, 2013.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 5
9:38 a.m.
MR. BURCHFIELD: Daniels Exhibit 6 is a preliminary expert report by Dr. Daniels dated September 27, 2013.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 6
9:39 a.m.
MR. BURCHFIELD: And Daniels Exhibit 7 is a cover letter from Ms. Brault dated December 20, 2013, attaching addenda to preliminary expert report of Suzanne M. Daniels dated December 16, 2013.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 7
9:39 a.m.
BY MR. BURCHFIELD:
Q. Okay. Dr. Daniels, let's start with Daniels Exhibit 4 and Daniels Exhibit 5. I'll hand those to you.
My first question is for Daniels Exhibit 4 entitled Declaration of Suzanne M. Daniels. Is that

in fact a declaration that you executed on or about June 3, 2013?
A. Yes.
Q. And was that declaration executed in conjunction with Daniels Exhibit 5, which is your June 3, 2013, preliminary expert report?
A. Yes.
Q. The -- and then Daniels Exhibit 5 is your preliminary expert report dated June 3, 2013, correct?
A. Yes.
Q. I don't intend to spend much time on this today, but let me just ask you: Daniels Exhibit 5, as I read it, seems consistent with but not as -- but doesn't -- but not as inclusive as Daniels Exhibit 6, which is your September 27, 2013, report; would you agree?
A. Would you repeat that, please?
Q. Sure. And it wasn't a very good question. Let me -- Daniels Exhibit 5 -- let me start from a different perspective.
Daniels Exhibit 6 contains everything that Daniels Exhibit 5 contains, but Daniels Exhibit 6 also adds some material that is not in Daniels Exhibit 5; would you agree with that?
A. With the exception that there may be some words that have been deleted that were typographical errors

Page 14

between the two.
Q. But you -- you would still stand by all the opinions expressed in Daniels Exhibit 5?
A. That is -- yes.
Q. And the opinions that you expressed in Daniels Exhibit 5 you would -- it would be your view that those are consistent with the views expressed in Daniels Exhibit 6?
A. Yes.
Q. So that will allow us to focus on Daniels Exhibit 6 today. And Daniels Exhibit 6 -- let me give that to you -- is your September 27, 2013, report, and just take a moment, confirm that what you have before you is, in fact, a copy of your September 27, 2013, report.
A. Yes.
Q. Okay. Daniels Exhibit 7 is your -- is an addendum to that preliminary report, and can you confirm that Exhibit 7 is a correct copy of that addenda?
A. Yes.
Q. Dr. Daniels, I note that Daniels Exhibit 6 deems -- is deemed a preliminary expert report. Other than Daniels Exhibit 7, have you made any changes to the preliminary report dated September 27, 2013?
A. No.

Page 15

Q. At this moment do you intend to?
A. No.
Q. And as of -- as of today, do you intend to make any changes in the addenda that you submitted on December 16 which we've marked as Daniels Exhibit 7?
A. Not as of today.
Q. Okay. Are you continuing to do analysis in this case or, with the possible exception of preparation of additional documents for motions practice or potentially appearing to testify, is your work -- is your analytical work here done?
A. At this point I have not -- I'm not actively doing any other additional research.
Q. You don't have any further assignments from Plaintiffs' counsel?
A. I do not, that is correct.
Q. And as of this moment, you are not conducting any analysis that would reasonably lead to changes in either Daniels Exhibit 6 or Daniels Exhibit 7?
A. Correct. Yes.
Q. Okay. Let's look at your resume, which is at page 16 of Daniels Exhibit 6. And you had earlier indicated that the dates of your degrees would be in this document.
If you look at page 21, it indicates your

Page 16

Ph.D. was received in 1984 and your BA in 1980. Are those dates correct, so far as you know?
A. Yes. Right.
Q. At the present time you serve as the president of AECP. What is AECP?
MR. CANZANO: I believe it's --
THE WITNESS: AEPC.
BY MR. BURCHFIELD:
Q. AEPC. Sorry.
A. AEPC is a not-for-profit labor management purchase -- health care purchasing coalition.
Q. And can you describe what you mean by "health care purchasing coalition"?
A. On behalf of our -- AEPC's member organizations, we undertake bidding on the selection of preferred service providers and negotiate contracts with those preferred service providers that result in value to our members, both -- value being improved pricing and improved quality.
Q. And who are the members of AEPC?
A. Any entity that provides health care to at least one employee subject to under the terms of the collective bargaining agreement is eligible to be a member of AEPC.
Q. How many members do you have?

Page 17

A. Approximately 34.
Q. Forty-four?
A. Thirty-four.
Q. Thirty-four.
A. Approximately.
Q. And are they regionally based or nationwide?
A. They are regionally based.
Q. Can you describe the region?
A. Predominantly Michigan. We have one member organization in Kentucky and one in Ohio.
Q. And how many people work with you at AEPC?
A. I am the sole part-time employee.
Q. Okay. And if I'm understanding you correctly, and please feel free to correct me if I get this wrong, but AEPC, on behalf of its members, seeks favorable health insurance programs for those members to offer to their employees?
A. No, that's not correct.
Q. Okay. Can you tell me how I'm wrong and maybe rephrase it in a way that will be --
A. Sure.
Q. -- that I can understand?
A. Certainly.
The members of AEPC largely are self-funded employers or -- and/or Taft-Hartley Trusts, other

Page 18

trusts. They're largely self-funded.
Q. Yep.
A. So they, for example, would be providing a prescription drug benefit through a pharmacy benefit manager, Express Scripts, CVS Caremark. We, working with a consultant, go out to bid for a pharmacy benefit manager, because 180,000-plus lives will be covered if we add up all the members, the employees and retirees, of the various AEPC members. They receive more favorable pricing from a pharmacy benefit manager than if any one of them went out to the marketplace on their own. Similarly for vision, a self-funded PPO network, and the like.
But it's not insurance.
Q. Is the -- thanks for that clarification.
Do all the members of AEPC offer the same plan?
A. No. A coalition would never be successful if we required each one of those 30-plus entities to have the same plan design.
Q. And about how many different plans are there among the AEPC members?
A. Oh, you can multiply the 34 by, like, two and a half, three times, because some of the trusts have multiple plan designs.

Page 19

Q. Is it typical within the group of AEPC for an employer to have a -- one plan for its employees and a separate plan for its retirees?
A. Sometimes, yes. It's not -- I wouldn't say it's typical. It happens, yes.
Q. Is it typical for members of AEPC to have a separate plan for their unionized work force and a different plan for their salary work force, nonunionized work force?
A. It's not an area that we spend a lot of time on, because the focus of AEPC is only on those employees that have health care through a collective bargaining agreement. So what they're doing for other workers is not something that we discuss at any level of detail.
Q. Do the plans that AEPC members offer typically have deductibles for prescription drugs?
A. Plan design is left up to the employ -- to the participating AEPC member organization.
As far as deductibles for prescription drugs, it would be atypical to see that among the group right now.
Q. How about -- how about copays for prescription drugs?
A. Yes, there are copays for prescription drugs.
Q. And that would be typical?
A. Yes.

Page 20

Q. How about --
MR. CANZANO: Could I just stop, just because I didn't get the previous question? What was the prior question?
MR. BURCHFIELD: Do you want to read it back?
(The following portion of the record was read by the reporter at 9:53 a.m.:
Question: "Do the plans that AEPC members offer typically have deductibles for prescription drugs?".)
MR. CANZANO: Okay. You can go ahead.
MR. BURCHFIELD: Thank you.
BY MR. BURCHFIELD:
Q. Do some of the AEPC plan -- member plans have deductibles for prescription drugs, to your knowledge?
A. Not that I'm aware of.
Q. How about coinsurance for prescription drugs; do the plans offered by AEPC typically have coinsurance for prescription drugs?
A. There are some that have coinsurance.
Q. Do you know if that would be a majority of the plans or less than a majority of the plans?
A. Far less than a majority of the plans.
Q. How about for medical services; do the AEPC members

Page 21

typically have deductibles for the medical services in their plans?
A. AEPC has not gone to bid or done anything on the medical side for the last seven years, so any -- I don't have current knowledge of their medical plan designs.
Q. You've been at AEPC since 2006, according to -- actually, you were at AEPC as executive director going back to 2004, it looks like; is that correct?
A. That's correct.
Q. And so was there a period of time during which you were at AEPC that AEPC did become involved in negotiating medical plans for its members?
A. Yes.
Q. And at that point in time did those medical plans have deductibles?
A. Some did.
Q. Did most?
A. I can't say. I don't recall.
Q. At that time when AEPC was negotiating medical plans for its members, did those medical plans have copays?
A. Yes.
Q. All?
A. I can't say all, no.
Q. But you're confident that most did?

Page 22

A. Many did.
Q. And how about -- how about coinsurance for the medical plans that you were familiar with?
A. I don't recall specifically if there was a coinsurance plan.
Q. Why did AEPC cease its involvement with medical plans for its members?
A. It's the market dynamics of Michigan. With a prominent -- with a dominant carrier, there's very little that one can do to influence pricing in the marketplace.
Q. Is that Anthem Blue Cross Blue Shield?
A. No, it's Blue Cross and Blue Shield of Michigan.
Q. Okay. How do you see the Patient Protection and Affordable Care Act affecting the mission of AEPC, if at all?
A. We're continuing, certainly, to -- it has impacted our mission. We're focusing on -- we have greater focus on educating our member organizations on certain pieces of the ACA. We're monitoring the pieces that are still kind of up in the air.
So we don't have a definitive, you know, this is the game plan because of ACA, because ACA is a work in progress.
Q. What's the educational component of the plan -- of

Page 23

AEPC with regard to the AFA (sic)?
A. We've been bringing in speakers to our meetings to discuss various aspects of the Affordable Care Act, as well as speakers on other topics, such as new products and -- for the marketplace.
Q. Who are the audience -- who are the audiences for those speakers? Are they the individual insured lives, or are they the administrators or managers of the programs?
A. They're the administrators or HR staff.
Q. Okay. In the market as you see it at the present time, do the members of AEPC offer, from member to member, do they offer plans that vary in the levels of coverage provided to the insureds?
A. The members of AEPC are very diverse, ranging from universities to heat and frost insulators. So yes, there's variation in plan design somewhat reflective of the type of organization and their historical starting points.
Q. Do the members of AEPC uniformly offer employee-funded coverage for their retirees?
A. Not --
MR. CANZANO: Employee funded?
THE WITNESS: Yeah, I don't understand the question.

Page 24

BY MR. BURCHFIELD:
Q. Okay. Let me ask it again.
If you ever don't understand a question, let me know. I often misspeak, as my wife reminds me more than daily.
Do the members -- do the members of AEPC uniformly offer retiree health coverage to their employees, to their former employees?
A. Could you clarify what you mean by "uniformly"?
Q. Do they all?
A. No, they do not all.
Q. What percentage do and what percentage don't?
A. Can't tell you. I don't know.
Q. With regard to those that do provide retiree health coverage, have you had occasion to compare the retiree health coverage that is provided by the AEPC members to the proposed plan in this case?
A. No.
Q. Have you had occasion to compare the retiree health coverage that is provided by the AEPC members, for those that provide it, to the retiree health plan that the plaintiffs in this case currently are under?
A. No. That would be outside the scope of work.
Q. You weren't asked to do that?
A. No. It's outside of what I was asked to do.

Page 25

Q. So you don't have an opinion on whether the proposed plan is as good as, better than, or not as good as the plans offered by the -- to retirees by the members of your organization?
A. I do not have an opinion as that was not part of the scope of work.
Q. Okay. Your resume also indicates that you currently are the committee chair of four VEBAs, voluntary employee benefit associations. Does that remain true?
A. Yes. They're beneficiary associations, not benefit associations.
Q. Okay.
MR. BURCHFIELD: Ask the reporter to mark as Daniels Exhibit 8 a motion filed in the United States District Court for the Eastern District of Pennsylvania in the case of Mack Truck versus International Union, United Automobile Aerospace & Agricultural Implement Workers of America, and it looks like it's dated March 18, 2011.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 8
10:03 a.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, I'm handing you what's been just marked as Daniels Exhibit 8. Would you please take a moment

Page 26

to look at that.
MR. CANZANO: Do you have a copy of that for me?
MR. BURCHFIELD: Oh, I do. I'm sorry, John.
BY MR. BURCHFIELD:
Q. And while you're looking at that, let's mark as Daniels Exhibit 9 a document with a cover page that has summary plan description for the Mack Trucks, Inc., restructured plan.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 9
10:04 a.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, as you go through that my question for you, which you can think about as you're going through, is: Does Daniels Exhibit 8 relate to the -- to the VEBA plan for which you serve as committee chair?
A. Yes.
Q. Let me -- let's stay on Exhibit 8 for a minute, and then we'll turn to Exhibit 9. Let me ask you to turn to page 8 of Daniels Exhibit 8. Let me back up for a second.
How long have you been the committee chair

Page 27

of the Mack Truck VEBA?
A. Oh, it would be beginning after the -- let me just look. I can tell by when the funding began and the VEBA was started, which should be in here. So not until the VEBA was actually up and running. There's a date in here, I'm sure. Payments.
So it was, like, 2011 or 2012, based on page 9.
Q. Okay. So, but you -- taking your comment, were you on the VEBA committee for the Mack Truck plan from the time the VEBA was initially started?
A. Yes.
Q. Okay. And did that VEBA result as part of a settlement of a dispute between the UAW and Mack Trucks regarding, at least in part, retiree health benefits?
MR. CANZANO: I'm going to object to foundation.
BY MR. BURCHFIELD:
Q. You may answer.
A. I don't know the complete history behind what precipitated the formation of the VEBA.
Q. Let me ask you to look at -- well, let me back up for a second.
Do you have any understanding of the

Page 28

historical prelude to the VEBA?
A. Only that it was a settlement agreement that came about that formed the VEBA.
Q. Let me ask you to look at Daniels Exhibit 8 on page 8, at the last paragraph there, and I'll read this into the record. And I'm just -- I'm interested in whether this is consistent with your understanding.
It says, quote, The benefits under the restructured plan are reduced from the retiree medical benefits in effect prior to the restructured plan's October 1, 2009, effective date. The restructured plan requires some cost-sharing by participants, including annual deductibles and copayments. For example, non-Medicare-eligible participants in the Highmark PPO network must pay a larger share of their medical expenses depending on whether they use a PPO network provider, 20 percent in-network as compared to 40 percent out-of-network. The restructured plan also requires monthly contributions by participants in order to maintain coverage. The amount of the monthly contribution depends on the retiree's date of retirement, or the date of an employee's death for a surviving spouse of a retirement-eligible employee, as well as whether single or family coverage is selected, and whether the participant is medical --

Page 29

Medicare-eligible. For example, the current monthly contribution for family coverage, two or more persons, for a retiree who retired between December 2, 2004, and July 1, 2009, is $320 for a non-Medicare-eligible family and $160 for a Medicare-eligible family?
Do you see that?
A. Yes.
Q. Does the statement that I've just read into the record comport with your understanding of the terms of the Mack Truck VEBA plan?
A. I believe so, yes.
Q. So it would be fair to say --
A. Excuse me. Let me --
MR. CANZANO: Go ahead.
THE WITNESS: The Mack Truck VEBA plan? Let me -- what you read is the restructured plan that went into effect in 2009.
BY MR. BURCHFIELD:
Q. And does the plan -- does the VEBA provide benefits that are different from this restructured plan?
A. Yes.
Q. How does the VEBA differ at all from the, quote, Restructured plan, unquote, if at all?
A. There are changes in the benefits as well as changes in the carriers.

Page 30

Q. Under the VEBA?
A. Correct. Yes.
Q. Does the VEBA discontinue copays, deductibles, or premiums for the participants in the plan?
A. I cannot say that. There are not -- let me say that differently. Let me rephrase that.
There have been changes, so in some cases it is possible that a copay has been modified and -- and/or eliminated.
Q. Deductibles?
A. I don't believe those have been modified.
Q. Premiums?
A. I don't -- there are premiums.
Q. And have those premiums been increasing?
A. To the best of my recollection, no.
Q. When was the last time they increased?
A. I don't recall.
Q. Just to make sure the record is clear, is there a separate Mack Truck Restructured Plan that is a different plan than the one administered through the VEBA?
A. Yes.
Q. Okay. And what is the difference between the Mack Truck Restructured Plan and the benefits administered through the VEBA?

Page 31

A. As I stated earlier, there's a change in the carrier. Under the Mack restructured plan, benefits were provided in part through Highmark Blue Cross and Blue Shield, prescription drugs were provided through Catalyst, and that is no longer the case.
Q. Well, and I apologize, this is -- these questions are a little bit difficult for me to ask -- to phrase.
Is there -- do the terms of the VEBA and the carriers used by the VEBA supersede the Mack Truck Restructured Plan?
A. The VEBA is responsible for determining plan design.
Q. Determining what?
A. The plan design, the carriers --
Q. Right.
A. -- everything going forward.
So yes, if supersedes means does it replace what was the restructured plan for those participants covered through the VEBA, it is the VEBA plan they are covered by.
Q. You mentioned that some copayments may have been reduced or eliminated. Are there currently any copayments in the Mack Truck VEBA plan?
A. There are copayments.
Q. And what's the highest of those copayments, as best you recall?

Page 32

A. They're very -- I don't -- perhaps for prescription drugs there could be a $30 for the middle tier drugs.
Q. How about coinsurance; is there -- is there still coinsurance under the Mack Truck VEBA plan?
A. I'd have to look at the summary plan description to be certain.
With four VEBAs -- with four very different approaches covering both pre -- non-Medicare eligible, Medicare eligible, quite candidly at the committee we have to have in front of us the grid of all the benefit designs. It's not something you want to commit to memory.
Q. Do you -- well, do you have an opinion on whether -- and, well, let me -- I'll get to that in a second.
Let's look at Daniels Exhibit 9 for a minute, which is the summary plan description for the Mack Trucks, Inc., restructured plan, and it says, This booklet describes the plan as in effect on and after January 1, 2011.
Do you see that? It's the second page of Daniels Exhibit 9.
Oh, I'm sorry. It's this one.
A. Okay. I wasn't handed it, so -- yes, I see.
Q. Is there a more current summary plan description for the Mack Truck Restructured Plan than Defendants'

Page 33

Exhibit 9 dated January 1, 2011?
A. Yes.
Q. And what's the date of the most recent restructured plan, SPD?
A. 2012.
Q. Is it --
A. Is my understanding.
Q. Is -- how frequently is the SPD revised?
A. Based on the need to revise it as determined by legal counsel.
Q. When it was revised -- if you recall, when it was revised from the 2011 SPD to the 2012 SPD, did the program become more or less generous to those covered by it?
A. I struggle with the word generous.
Q. All right. You may use whatever term you want.
Is there any way -- how would you compare the 2012 revised SPD to the 2011 SPD that's marked as Daniels Exhibit 9?
A. The benefits did not markedly change.
Q. Did deductibles go up or down?
A. I don't believe they changed.
Q. How about copays?
A. Again, I do not believe they changed.
We restructured part of the prescription

Page 34

drug benefit on the third tier, so it's a little confusing, but they did not diminish the benefits.

Q. And what do you mean, restructured the prescription drug benefits on the third tier?

A. Because of a coinsurance provision and an out-of-pocket max, it was tweaked on the Medicare side, is my recollection, just to be more logical, and because of the way it was designed before was not -- is kind of not the standard way you would do it.

Q. Can you be more specific? None of this is particularly logical to me, but --

MR. CANZANO: I'm just going to --

THE WITNESS: Oh, boy, I'd have to go back and look at this.

MR. CANZANO: At this point I'm going to place an objection on the record. I'm not sure where you're going with this or how far you're going with this, but the scope of this witness's report and opinion here is not to compare --

THE WITNESS: Yeah.

MR. CANZANO: Let me speak.

THE WITNESS: Okay.

MR. CANZANO: -- is not to compare different plans or different plan designs all over the country that she may or may not have knowledge of.

Page 35

I'm reluctant to obstruct, because I want to let you have your ability to get into her opinion, but if we're going to go down that road, I will be objecting more, and we may have to take a different approach here.

MR. BURCHFIELD: Okay. That's noted.

Is there a question pending? Would you read it back, please?

(The following portion of the record was read by the reporter at 10:18 a.m.:

Question: "Can you be more specific? None of this is particularly logical to me, but --".)

BY MR. BURCHFIELD:

Q. Yeah, the question is: You were talking about the third tier prescription drug benefit was changed to make it more rational, and I'm just interested -- those weren't exactly the terms you used, but I'm just interested if you could be a little bit more specific about what you meant by that.

A. We made a change that addressed the specialty being a forth tier and not -- rather than being considered, as I recall, a nonpreferred. So rather than have a four-tier plan, it was moved to be a more typical, three-tier plan. That's my recollection.

Page 36

Q. And you're obviously the expert on this. In a typical, three-tier plan, could you just briefly indicate what each of those three tiers -- how you would describe each of those three tiers?

A. First tier, tier 1, the lowest copays would be generic drugs, the second tier would be formulary brand, and the third tier would be non-formulary brand.

Q. Okay. That's helpful. Thank you.

Let me ask you a question on page -- if you turn to page 26 of Daniels Exhibit 9, I see about the middle of the page there it says, Lifestyle drugs not covered.

Do you see where that is?

A. I do.

Q. And says, The plan does not cover any prescription drugs that are used solely for cosmetic purposes or that are used on a discretionary or medically-unnecessary basis.

Do you see that?

A. I do.

Q. And is -- under this plan is a drug like Viagra considered to be a lifestyle drug?

A. Lifestyle drug is not a defined term in the industry, and as such it's one that we, as a committee, tend not to use. So without looking at the summary plan

Page 37

description, I would have to refresh my memory as to whether or not Viagra is included or excluded.

Q. Okay. Let me ask you, Dr. Daniels, if you have an opinion, if you have formed an opinion, on whether the benefits provided to retirees who participate in the Mack Truck VEBA Program are more, less, or about the same in terms of the coverages than the plan proposed by CNH in this case.

MR. CANZANO: I'm going to object to the question on the basis that it goes beyond the scope of the opinion and the scope of the report that she's been asked to give in this case.

THE WITNESS: I have no such opinion as it is beyond the scope of the work that I was given to do, asked to do.

BY MR. BURCHFIELD:

Q. Okay. You were also the chair of a committee on the St. Joseph UAW Health & Welfare Trust; is that correct?

A. Yes, it is correct.

MR. BURCHFIELD: Let me mark as Exhibit 10 a document with the legend The UAW St. Joseph Health & Welfare Trust, Summary of Benefits.

MARKED BY THE REPORTER:

DEPOSITION EXHIBIT 10

Page 38

10:23 a.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, do you have in front of you Daniels Exhibit 10?
A. Yes.
Q. Am I correct that this is -- this document is a summary of benefits for the UAW St. Joseph Health & Welfare Trust for the period January 1, 2011, through December 31, 2011?
A. Yes.
Q. And is this, at least during that period of time, was this the plan that was provided pursuant to the St. Joseph UAW Health & Welfare Trust of which you are the committee chair?
A. This is the plan that was in effect for the period of January 2011 through December 31, 2011, for the VEBA, St. Joseph.
Q. And under this plan are the Medicare-eligible retirees expected to participate in Medicare Part B?
A. Yes.
Q. And are the Medicare-eligible retirees expected to participate in Medicare Part D?
A. Medicare Part D would not -- is not relevant to this group.
Q. Why is that?

Page 39

A. This is a Medicare Advantage product which includes prescription drugs.
Q. Is there any -- does it in any way deem Medicare Part D as primary coverage and then layer on top of that additional -- additional coverage?
A. I don't understand your question.
Q. Let me ask you to look at page 19 of the plan.
A. Yes.
Q. You got it?
A. Um-hum.
Q. It says in the right-hand column there, it says, Part D prescription drugs, and --
MR. CANZANO: What page?
THE WITNESS: Nineteen.
MR. BURCHFIELD: Page 19.
BY MR. BURCHFIELD:
Q. And I guess my question is: What's the relevance of the reference to part D prescription drugs there if Medicare Part D is not relevant to these retirees?
MR. CANZANO: Hang on a second, because the copy that I have is about seven -- many page 20s and 21s, and I haven't found page 19 yet.
MR. BURCHFIELD: Okay.
MR. CANZANO: Nor does it appear to have a page 19.

Page 40

MR. BURCHFIELD: Dr. Daniels, you have a page 19, right?
Maybe you can look over her shoulder as we --
MR. CANZANO: Found it.
MR. BURCHFIELD: Okay.
BY MR. BURCHFIELD:
Q. The question is: What's the relevance of the reference to part D prescription drugs there if Medicare Part D is irrelevant to this plan?
A. The reference is relevant because it's defining what drugs are covered through the plan. But it's not a separate part D program, it's all one in the Medicare Advantage.
Q. So does -- if a participant in the UAW St. Joseph Health & Welfare Trust receives prescription drugs, does Medicare pay anything for those prescription drugs?
A. This is a Medicare Advantage program, so there is funding for Medicare Advantage programs through CMS. So are you -- I don't understand what you're asking. Medicare doesn't cover prescription drugs.
Q. Part D doesn't cover prescription drugs?
A. But you asked about Medicare.
Q. I'm sorry. My question was imprecise. Let me

Page 41

rephrase it.
When a participant in the UAW St. Joseph Health & Welfare Trust receives prescription drugs, does Medicare Part D pay any amount in support of that prescription?
A. That -- what you're asking doesn't fit with how these programs are designed or how Medicare is set up.
This is a group Medicare Advantage product. It has the part D benefit all inside of that. An individual covered under this plan is not mean to have their own separate part D product -- program that they bought in the marketplace or something, if that's where you're going with this.
Q. That's not where I'm going with this.
A. I'm very confused.
Q. Well, let me see if I can clarify. Let me see if I can help clarify.
You understand the concept of primary coverage versus secondary coverage, right?
A. Yes, I do.
Q. Okay. Now, is it the case that in effect a participant in the St. Joseph UAW Health & Welfare Trust is expected to take full advantage of any benefits through the Medicare Advantage program before the St. Joseph UAW Trust pays anything?

Page 42

A. The trust is paying a premium to Blue Cross for this plan. This is their sole coverage.
Q. Right.
A. It's not like there's a supplemental plan or a wrap plan. This is where they get all of their benefits through.
Q. And the government does not pay a penny in support of those prescription drugs; is that what you're saying?
A. No, that's not what I'm saying.
Q. Okay. I thought that was my question.
Let me ask the question a little bit more directly, or let me reask the question I think I already asked you directly, but let me reask the question so we're clear.
A prescription recipient under the UAW St. Joseph Health & Welfare Trust would receive funding through Medicare Part D for the prescription drugs as part of the Medicare Advantage Plan; is that correct?
MR. CANZANO: The recipient receive funding? Was that the question?
THE WITNESS: Restate the question.
BY MR. BURCHFIELD:
Q. Would part of the funding for a participant's prescription drugs come from Medicare Part D?

Page 43

A. Blue Cross and Blue Shield of Michigan, in offering a Medicare Advantage product to the market, does receive a subsidy from CMS.
Q. And that is -- and that -- and the UAW St. Joseph Health & Welfare Trust benefits from that subsidy?
A. The -- yes.
Q. Okay.
A. Indirectly, yes.
Q. Am I correct that the UAW St. Joseph Health & Welfare Trust has deductibles for the services provided?
MR. CANZANO: Can we just go off the record for a second before we continue on?
MR. BURCHFIELD: Let's finish this line of questioning first.
MR. CANZANO: Okay.
THE WITNESS: There is no deductible for in-network services, and there is no coinsurance for in-network services.
BY MR. BURCHFIELD:
Q. But there is for out-of-network deductible and coinsurance; is that correct?
A. The document states that there is cost-sharing provisions for out-of-network services.
Q. And on page 2 it indicates that under Medicare -- under the two right-hand columns, under the heading

Page 44

Medicare Plus Blue -- Plus Blue Group PPO, under in-network it says, In addition to your Medicare Part B premium, you may also be required to pay premium contribution as defined by your employer or union group.
Do you see that?
A. I do see that.
Q. Do you know if the St. Joseph -- if the participants in the UAW St. Joseph Health & Welfare Trust are required to pay such a premium?
A. My recollection is that they do not have a premium contribution that's required.
Q. Do they pay the Medicare Part B premium?
A. Medicare Part B premium is paid, but it may be through their pension as a negotiated benefit that was in place at the time of their retirement.
Q. Okay. Have you formed an opinion as to whether the benefits proposed by CNH for the class plaintiffs in this case are as good as, better, or not as good as the benefits provided through the UAW St. Joseph Health & Welfare Trust?
MR. CANZANO: Objection, beyond the scope of the opinion that she's been asked to give.
THE WITNESS: I have no such opinion as that's beyond the scope of the work I was asked to

Page 45

perform.
MR. BURCHFIELD: Okay. Let me ask the reporter to mark as Daniels Exhibit 11 --
MR. CANZANO: Before we move on, if we could go off the record.
(Off the record at 10:35 a.m.)
(Back on the record at 10:36 a.m.)
MR. BURCHFIELD: Let me ask the reporter to mark as Daniels Exhibit 11 a document entitled UAW Retirees of the Dana Corp Health & Welfare Trust for the period January 1, 2011, through December 31, 2011.

MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 11
10:37 a.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, I'm handing you Daniels Exhibit 11, and take whatever time you'd like to review that, but my question for you is: Does this appear to be the summary of benefits for the UAW Retirees of the Dana Corporation Health & Welfare Trust of which you served as cochair -- of committee chair from the period January through December 2011?
A. That reflects the benefits for the Medicare-eligible plan participants of the trust.

Page 46

Q. Okay. Could you look, please, at page 6 of the document, under section 2, summary of benefits, and under the heading Medicare Plus Blue Group PPO In-Network? Are you with me?
A. Um-hum.
Q. Yes?
A. Yes.
Q. Thank you.
You see about halfway down the page there it says, For many coverage services described below, the following cost-share applies: Services are subject to the annual deductible of $300. Services are subject to a coinsurance of 20 percent. There is an in-network annual out-of-pocket maximum of $1500.
Do you see that?
A. I do.
Q. And do you know if the current version of the UAW Retirees of the Dana Corp Health & Welfare Trust continue to have the deductible and coinsurance provisions?
A. For the Medicare-eligible population in the trust there are deductibles and coinsurance provisions.
Q. How about for the non-Medicare eligible, do they also have deductibles and copays -- coinsurance? I'm sorry.

Page 47

A. There are cost-sharing provisions for the non-Medicare eligibles.
Q. Do you recall whether the cost-sharing provisions for the non-Medicare-eligible retirees are higher; in other words, whether they impose higher costs on the non-Medicare-eligible retirees than the ones we see here for the Medicare-eligible retirees?
A. Can't -- I don't know with certainty, but there -- the work -- we do work to align them so that -- to the extent possible. We don't have a lot of flexibility with the Medicare Advantage product, however, so that's why you see differences.
Q. And you say you don't have a lot of flexibility. What is the -- what is the reason for the lack of flexibility?
A. Because Medicare Advantage is overseen and regulated by CMS under some Medicaid and Medicare services, and they have guidelines for what the plan designs have to be and what's covered and the like. So the carriers have to file those plans.
Q. And I just -- I want to make sure I understand your answer. On Daniels Exhibit 10, which is the UAW St. Joseph Health & Welfare Trust, we saw and you testified that there were no in-network deductibles or coinsurance, yet for a contemporaneous Medicare Plus plan for the same period of time for the Dana Corporation retirees, we do see deductibles and coinsurance. I don't understand how one could be consistent with inflexible CMS policies and the other also consistent with those policies.
A. As I noted, CMS has standard plan designs that they will accept, so there's a menu of plan designs, such as reflected here. So there is some flexibility, but not endless flexibility. So I couldn't say I want an ER co -- emergency department copay of $13.50 for Medicare Advantage. That's not permitted.
So there's permitted benefit levels, and each of these have different permitted, permissible benefit packages.
Q. But it is consistent with CMS policy for plans to contain deductibles?
A. Yes.
Q. And coinsurance?
A. CMS permits that.
Q. And copays?
A. I believe so, yes. We see that on the prescription drug side.
Q. And CMS also permits differentiation between patients who receive their benefits in-network versus patients who receive their benefits out-of-network?

Page 49

A. Under the Medicare Advantage programs there are -- differentials between in-network and out-of-network services are permitted, although very few services are ever rendered outside network.
Q. And in your view is that because the incentives to stay in the network are so strong?
A. It's a multifaceted -- there's multi reasons, multiple reasons, why people stay in-network, but usually the breadth of the network is sufficient that people continue to stay in network.
Q. But the financial incentives are significant to stay in the network, right?
A. Depending upon ones income, the incentives may or may not be significant.
Q. And is there a -- do you have an amount of income threshold at which they become insignificant?
A. No, but one could imagine, certainly, if you were someone that was a multimillionaire --
Q. Warren Buffett wouldn't care.
A. He wouldn't care. Exactly. That's my point.
Q. But for purposes of the class of plaintiffs we're dealing with here, it would be true, wouldn't it, that the incentives to stay in the network, the financial incentives to say in the network, are significant to stay in the network to the class of plaintiffs here?

Page 50

A. That's not what I was asked to look at.
Q. So you don't have an opinion on that?
A. I don't.
Q. Okay. This -- we've been going for about -- how long? Let's go for a little bit longer. We can get a little bit more done, I think. I'm eager to get you out of here with appropriate dispatch.
And as with the other benefit plans, you weren't asked to form an opinion as to whether the Dana Corp plan was more generous, less generous, or about the same as the CNH proposal here, were you?
A. I was not asked to form an opinion.
Q. And you don't have an opinion?
A. I was not asked to form an opinion.
Q. I take it --
A. Beyond the scope of my work.
Q. And so I take it that means you don't have an opinion.
A. That is correct.
Q. Thank you.
Dr. Daniels, your work in the health care area has -- I assume that you have followed the issues of some of the major entities in the Detroit area with regard to their retiree health care liabilities; is that right?
A. Could you be more specific?

Page 51

Q. Sure.
A. -- as to the entities?
Q. Sure.
You know that both business and governmental entities in the greater Detroit area have had -- have struggled with their retiree health care liabilities in recent years, right?
A. There are some entities that have struggled in recent years.
Q. In fact, the former treasurer of the state of Michigan opined in court just a couple of weeks ago that the principal reason Detroit went into bankruptcy was retiree health care benefits.
Didn't you -- did you read that?
A. I read that.
Q. And do you disagree with that assessment?
A. Detroit is far more complex than just retiree health care as it relates to the bankruptcy.
Q. But you would agree that the retiree health care obligations of Detroit are at least a material contributing factor to Detroit's decision to go into bankruptcy?
A. They are a factor. I have not personally reviewed the numbers to say whether or not they are material -- it's a material reason.

Page 52

MR. BURCHFIELD: Let me ask the reporter to mark as Daniels Exhibit 12 an article from the Detroit Free Press dated November 5, 2013, entitled Dillon: Retiree Health Care, Not Pension Shortfall, a Core Reason for Detroit Bankruptcy.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 12
10:48 a.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, do you have in front of you Daniels Exhibit 12?
A. I do.
Q. And do you see there in the first paragraph it says, Former Michigan Treasurer Andy Dillon said Tuesday that Detroit's retiree health care commitment was a core reason why the city filed for bankruptcy and that the city's pension shortfall wasn't the driving factor, unquote?
A. I see that language.
Q. And that -- and you saw the news reports of that testimony, I assume?
A. I did not see this one.
Q. Dr. Daniels, would you agree with me that every day CNH's ability to implement the changes that it's proposing in retiree health care benefits are delayed,

Page 53

the retirees receive a financial benefit?
A. I don't think I can answer with a simple yes or no.
Q. And what about the question do you find difficult?
A. "Every day."
Q. Well, let's say every month. Would you agree that every month the changes that CNH is proposing are delayed that the class of retirees in this case receive a financial benefit?
MR. CANZANO: I --
THE WITNESS: No.
MR. CANZANO: I'm going to object because it assumes -- it assumes that there is a right to make that change.
MR. BURCHFIELD: I don't -- I don't -- if that's the way you understood the question, let me make sure that that assumption is not reflected in the question.
BY MR. BURCHFIELD:
Q. In the event CNH were to have a right to make the changes, every month that those changes are delayed the retirees receive a financial benefit, correct?
A. Retirees who access services will pay less than under the proposed plan.
Q. And that's a benefit to them?
A. Correct.

Page 54

Q. And similarly, for every month that the changes are delayed, assuming that CNH ultimately is allowed to make them, CNH suffers a financial detriment?
A. They incur a cost.
Q. And that's a financial detriment?
A. Dependent -- whatever you want to -- however you're defining detriment. Those are not my words.
Q. Well, you're an economist. Do you not consider incurring cost to be a detriment to a business?
A. No, I don't, because oftentimes you incur costs as part of, like, research and development. So it's an investment.
Q. And is there any -- do you see any return to CNH from the cost of providing more generous benefits to this group of retirees than not -- than providing less generous benefits to this group of retirees?
A. There can be. It's --
Q. And what would that be --
A. -- perception.
Q. -- Dr. Daniels?
A. Perception in the marketplace.
Q. And how would one go about valuing it?
A. I don't know how one would value it, but certainly, if you look at companies that are attractive to work for and that are ranked high, it's because of the benefit

Page 55

packages that they provide both to current and retired workers.
Q. So is there any other benefit that you could potentially conceive of to the continuing cost to CNH for providing these benefits other than a potential public perception?
A. The other benefit is that retirees will have -- long-term health care costs can be contained by providing a population access to care without barriers that discourage them from getting care on a timely basis and getting preventive care, taking their medications and the like. So there is a financial upside to all of this.
Q. Um-hum. And you're familiar -- you're aware that under the Affordable Care Act there are four categories of preventive care that are not -- that cannot be restricted, right?
A. Correct.
Q. And taking that into account, have you seen any quantification of the long-term financial benefit to a company of offering benefits without cost-sharing versus benefits with cost-sharing, assuming --
A. Yes.
Q. -- those four categories of preventive services are covered?

Page 56

A. Yes.
Q. And what study?
A. There are employers -- most notable is probably Pitney Bowes -- who went forth, and eliminated, reduced -- and others have followed -- and have zero copays on generic drugs often, for certain classes of drugs, because the data and the research that they conducted showed that it lowered health care costs overall, because the members -- their employees were able -- took their medications and were compliant.
Q. I don't see Pitney Bowes referred to anywhere in your report.
A. That's right, because that's active workers, and...
Q. Okay. Am I correct, Dr. Daniels, that the UAW agreed to all the changes in the 2005 plan for its current -- for the current unionized employees and for subsequent retirees?
MR. CANZANO: Objection to foundation.
THE WITNESS: I don't know. I was given the documents with the plans that are cited in my report.
BY MR. BURCHFIELD:
Q. You would agree with me, as a health care economist, that cost savings are not necessarily equivalent to cost shifting?

Page 57

A. Repeat the question, please.
Q. You would agree with me that cost savings are not necessarily equivalent to cost shifting?
A. Savings can be achieved without a cost shift.
Q. By, for example, moving from branded to generic drugs?
A. That is an example.
Q. Or mail-order prescription drugs?
A. Correct.
Q. Or requirements that drugs be purchased in quantities such as 90 days rather than in shorter allotments?
A. That actually works the opposite way oftentimes.
Q. It works the opposite way, meaning that if you order more from the drug distributor they will charge you more for a 90-day supply than for a 30-day supply?
A. Your question, as I interpreted it, was about savings, and I'm looking at savings in a macro way.
Q. Um-hum.
A. So it would be not -- you would not save by having individuals immediately fill a prescription for 90 days. You only want 90-day scripts to be for maintenance medications, medications they have been on for a while.
Q. Um-hum.
A. So to say that the 90-day supply -- the way that you've phrased it is not correct. In fact, you want

Page 58

them to have had -- like, been on it for a month to two months before you have them do a 90-day supply.

Q. My question may have assumed that a doctor would not write a prescription for 90 days or more unless the patient needed the drugs for 90 days or more, so let's work that into our assumption.

You would agree with me that, if a patient has a prescription for maintenance medications and buys them in 90-day allotments versus 30-day allotments, that that can be a cost saving that does not result in a cost shift to the patient?

A. Agree with that for maintenance drugs.

Q. And you would also agree with me, wouldn't you, that moving patients from out-of-network where the payments are at the usual and customary rate, into a network with negotiated, discounted rates, would be a cost saving that would not shift cost to the patients?

A. If the network -- in-network -- if the provider network that is considered in-network is broad, then it is not a cost shift. Because there are sufficient providers, hopefully that were selected based not just that they would take a discount, but based on clinical outcomes, then it would not be a cost shift.

Q. So -- but with a broad network the payment of negotiated charges in-network could result in cost savings versus out-of-network care without shifting any of the costs to the patients?

A. Again with the caveat with respect to the breadth of the network and the access that individuals have to those network providers must be reasonable.

Q. And you would also agree with me, wouldn't you, that at least in theory a shift by a company of costs to the government through existing government programs would not necessarily -- let me start again.

Would you agree with me that a company could save costs by shifting part of its cost to the government through government programs, and that doesn't necessarily lead to cost increases for the patient?

A. It is possible for, in a company, an employer to take advantage of current government-funded programs that will help contain their costs and not adversely impact and cost their retirees, active workers -- retirees in this case -- additional expenses.

Q. Dr. Daniels, how do you define managed care?

A. Managed care. A managed care plan product has programs and protocols that are focused on ensure -- on deliver -- ensuring that providers deliver care based on evidence-based, clinical guidelines, that members have timely access to care, that providers and plan members follow treatment protocols and those evidence-based guidelines.

Q. Is it a component of managed care, in your experience, that it typically works in conjunction with a network program?

A. Yes.

Q. And is it your experience that managed care typically works in conjunction with negotiated rates for -- with -- between the provider and the network providers?

A. Yes.

Q. Is it typically your experience that as part of managed care that participating providers in the network agree to, as you -- I think your term was evidenced-based treatment protocols?

A. Yes.

Q. And is it typical in managed care that precertification is required for certain services?

A. Historically managed care precertification was very -- was a core feature. It's waned in recent years.

Q. And why -- I'm sorry. Go ahead.

A. As -- well, again, that there's not always the need for it, that there were things that they used to do precert for all the time that they realized it cost more to do -- administratively to do the precert, because they were going to certify it anyhow. So there's less of that.

There's still some, but there's less than in the old days.

Q. Are you saying that precertification has declined for certain services or it's declined --

A. It's become more targeted.

Q. Okay. So it hasn't been -- it's not on the road to distinction across the board?

A. That is correct.

Q. Now, does -- is managed care, as you understand it, also consistent with the notion that patients get financial incentives to participate in the network as opposed to going out-of-network?

A. Yes.

Q. And the participating providers in a network can change year to year, right?

A. They can.

Q. And hospitals participating in a network can change year to year, too, can't they?

A. They can.

Q. Is it your understanding that managed care also has protocols -- sometimes has protocols for the use of generic or formulary drugs rather than branded drugs?

A. Yes.

Page 62

Q. I note from your resume that from 1987 to 1991 you were a staff consultant at the United Auto Workers, a senior staff consultant; is that correct?
A. Yes, it is.
Q. And during that time am I correct that the UAW had a policy of rejecting managed care proposals in the collective bargaining realm?
A. There was no such policy that I recall.
Q. Do you recall any situation in which the UAW entered a collective bargaining agreement with the sorts of managed care provisions that we've just talked about?
A. Yes.
Q. During the time you were there?
A. Yes. Towards the latter part of my tenure I was responsible for evaluating what are true managed care plans, HMOs, prior to them being offered to UAW members across the country. So managed care plans were prevalent.
Q. During the time that you were at the UAW did the UAW have managed care or HMO programs with material incentives for their use with GM?
A. I don't understand what you mean by, Material provisions for their use.
Q. Well, you can set up -- you can set up a program, but if there are no incentives for the employees to use

Page 63

it, it might not be used.
Do you recall whether -- do you recall whether the UAW, in its collective bargaining relations with GM during the time you were at the UAW, had a managed care or HMO program for UAW employees that incentivized them in a material way to participate in the managed care program as opposed to the indemnity program?
A. The UAW-represented employees at GM were offered a choice, and HMO benefits were significantly richer than under an indemnity plan.
Q. Was there any in-network incentives for the employees to use the HMO plan?
A. Under an HMO most -- if you want to use the terminology -- restrictive forms of managed care, there is no coverage if you go out-of-network.
Q. Well, there can be out-of-network coverage. We've seen that in some of the plans that your VEBA's administered.
A. Not in an HMO.
Q. What was the participation rate in the HMOs at GM during the time you were at the UAW in 1987 to '91?
A. I have no recollection.
Q. Do you recall if it was more than half?
A. I don't recall.

Page 64

Q. Okay. Were there any contracts -- were there any contracts that you're aware of that the UAW entered during your tenure there in which -- in which the beneficiaries, the employees, were -- had to pay out-of-pocket charges to go to a provider other than the HMO?
A. Your question doesn't make sense.
Q. What doesn't make sense about it?
A. Well, you asked would an employee have to pay out of pocket if they went to a provider other than the HMO. I either signed up for the HMO or I signed up for whatever other plan was offered, the indemnity plan or whatever. So I'm a little -- I'm confused by your question.
Q. Okay. Let me reask it then.
If an employee didn't sign up for the HMO, how did the out-of-pocket charges that the employee had to pay to take advantage of the non-HMO care compare to the out-of-pocket charges that the employee had to pay to go to the HMO during the time you were at the UAW?
A. As I stated, the benefits under the HMO were more generous than the other plan offerings.
Q. Yes. My question focuses on out-of-pocket costs to the employee.

Page 65

A. That's generous, I mean, in terms of dollars. The copays were lower under an HMO than under the indemnity plan.
Q. Do you recall by how much?
A. No, but I can say that there were many in HMO that had a zero drug copay, whereas in another plan it's 5/10, perhaps.
MR. BURCHFIELD: Let me ask the reporter to mark as Daniels Exhibit 13 a document dated April 23, 1984.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 13
11:12 a.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, if you could take a moment and look at Daniels Exhibit 13, and my question for you is whether you saw that during the time you were a senior staff consultant at the UAW from 1987 to 1991.
A. I do not recall seeing this letter.
MR. BURCHFIELD: Okay. Why don't we take -- what do you think? Ten minutes?
MR. CANZANO: Fine.
MR. BURCHFIELD: Okay. Great.
(Recess taken at 11:13 a.m.)
(Back on the record at 11:29 a.m.)

Page 66

MR. BURCHFIELD: Let's go back on the record.
BY MR. BURCHFIELD:
Q. Dr. Daniels, do you know or have you done any investigation about the percentage of retired Americans who rely exclusively on Medicare as their source of health insurance?
A. I have not.
MR. BURCHFIELD: I ask the reporter to mark as Daniels Exhibit 14 a document entitled Examining Sources of Supplemental Insurance and Prescription Drug Coverage Among Medicare Beneficiaries, dated August 2009, by the Henry J. Kaiser Family Foundation.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 14
11:30 a.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, do you have in front of you Exhibit 14?
A. I do.
Q. You have heard of the Henry J. Kaiser Family Foundation, I assume?
A. I am familiar with the Henry J. Kaiser Family Foundation.
Q. Okay. And do you consider the Henry J. Kaiser Family Foundation a credible source of information in the

Page 67

health care arena?
A. Yes.
Q. Let me ask you to look, if you would, at page 4 of Daniels Exhibit 14, and you'll see at the top a pie chart. And this is Exhibit 1.1 of the report, and it's entitled Sources of Supplemental Coverage Among Medicare Beneficiaries, 2007.
Are you with me?
A. Yes, I am.
Q. And it shows there none, Medicare fee-for-service only, 11 percent; do you see that?
A. I do.
Q. And then self-purchased only, 17 percent; do you see that?
A. I do.
Q. Twenty-two percent Medicare Advantage; do you see that?
A. Yes.
Q. And then Medicaid, 15 percent?
A. Yes.
Q. And then total number of beneficiaries, 40.8 million.
Do you have reason to question any of those percentages or numbers?
A. No. I would -- no.
Q. Now, Medicare Advantage we talked about a little bit

Page 68

before. Medicare is -- and let me just ask: Is Medicare Advantage always an employer-provided or -funded option for retirees?
A. No.
Q. Can private individuals, out of their own pockets, obtain Medicare Advantage plans?
A. Yes, they can now.
Q. Do you have any notion, Dr. Daniels, of whether it is more commonly employer funded or individually funded?
A. I don't know those numbers, no.
Q. Would it be fair to say, Dr. Daniels, that many millions of Americans rely exclusively on Medicare coverage for their health care coverage in retirement?
A. Based on this chart, 11 percent of Medicare beneficiaries rely solely on Medicare fee-for-service in retirement.
Q. And there are an additional complement of retirees who have no employer-funded component to their health care coverage; is that your understanding?
A. Based on this chart in 2007, from 17 percent that self-purchased additional coverage, 15 percent on Medicaid.
Q. And perhaps some portion of the 22 percent Medicare Advantage?
A. It's possible, but likely small, given the year.

Page 69

Q. Now, you've reviewed the proposed plan that CNH is advocating in this case; is that right?
A. Yes.
Q. And would you agree with me that the plan CNH is proposing for the Medicare-eligible retirees is more generous than Medicare standing alone?
A. I believe so, to the best of my recollection of what the plan design was.
Q. Okay.
A. Noting that it's Medicare standing alone.
Q. Correct.
Have you reviewed the reports of -- the report of Scott Macey in this case?
A. I was given the report of Scott Macey. I was asked to focus on a section of Scott Macey's report that related to my expert report.
Q. Did you review Mr. Stahl's report in this case?
A. I'm not sure.
Q. John Stahl, does that ring a bell?
A. No, it doesn't.
Q. Well, with regard to Mr. Macey's report, did you review the portion where he states that, Of the top 25 drugs used by Plaintiffs in recent years, a very large percentage of them didn't exist in 1998?
A. I was not asked to review that section.

Page 70

Q. Okay. You don't have any opinion on whether that's accurate or not?
A. I don't have an opinion to offer.
Q. Okay.
A. I wasn't asked to look at that.
Q. And Mr. Macey also addressed medical procedures on the basis of procedure codes, opined that a large percentage of the procedures that Plaintiffs are using now, the medical procedures that they're using now, did not exist is 1998.
Did you review that portion of his report?
A. I was not asked to review that portion of the report.
Q. So you don't have an opinion on that, either?
A. No, I'm -- no.
Q. All things being equal, Dr. Daniels, if the retirees are receiving drugs and medical procedures today that were not in existence in 1998, at no greater cost to themselves, is that an advantage to the plaintiffs, in your view?
A. They're receiving health care, and health care has changed over time, so there are things that were done in 1998 that we probably don't do today or do in the same way.
Q. Okay. My --
A. So they're receiving current health care.

Page 71

Q. Which is better than the health care standard in 1998?
A. It's certainly different. There's been progress, medical -- in the medical field.
Q. Okay. And do you -- you say, "progress." Is that a good thing or a not-a-good thing?
A. Actually it's a mixed bag.
Q. So you think --
A. Generally good, but like anything in this world, there can be a downside. There are providers that over prescribe, do excessive surgeries and the like, so there is a downside. Nothing is black and white.
Q. And over-prescriptions and excessive surgery you think have detrimental health effects?
A. That has been demonstrated, yes, in the research.
Q. Have you seen statistics on the extent of that?
A. I have not reviewed this document recently that I can cite the numbers, but the Dartmouth Atlas --
Q. Dartmouth?
A. Dartmouth Atlas.
Q. Atlas.
A. -- does and continues to do extensive research that focuses on the overutilization of services, in particular surgeries such as hip replacements, knee replacements. So it's variation in care after you've adjusted for differences in the population. It's

Page 72

regional variations.
Sorry.
Q. Oh, I'm sorry. I thought we had a water leak.
Now, under the proposed plan do you understand that the Medicare-eligible retirees would be entitled to use any provider that accepts Medicare?
A. Yes.
Q. And I thought I read something, Dr. Daniels, you know -- you may know whether this is accurate or not -- that the Patient Protection and Affordable Care Act has eliminated or closed the so-called doughnut hole?
A. It has made -- it has decreased the size of the doughnut hole; however, one will enter the doughnut hole earlier.
Q. Okay.
A. All right? I know, this is...
Q. It's arcane stuff, I know, but I'm with you so far.
So a lower -- the entry level for the doughnut hole has been lowered, but the ceiling for the doughnut hole has also been lowered?
A. Correct.
Q. And the net effect of that is to lessen the size of the doughnut hole, if I'm understanding you correctly?
A. That is the intent.
Q. And do you know what the intended -- do you know what

Page 73

the intended ultimate size of the doughnut hole is, taking into account the lower entry level and the lowered ceiling?
A. It's in the low $4,000 range --
Q. Versus --
A. -- for 2014. The difference is less than $200 in 2013.
Q. And is the --
A. My recollection.
Q. Is the expectation that the doughnut hole will continue to shrink?
A. Ultimately, and go away in, like, 2020.
Q. Okay. Let's turn back to your report the -- for a couple minutes. And this is Daniels Exhibit 6, your September 27, 2013, report. And let me just ask you some questions about your -- about your approach.
On page 25 -- actually, on page 25 of your report you set forth the fees you had charged, as I read it, as of September 27, 2013, of $8,000; is that right?
A. That's correct.
MR. BURCHFIELD: And let me ask the reporter to mark as Exhibit 15 an invoice from SNG Consulting to Darcie Brault.
MARKED BY THE REPORTER:

Page 74

DEPOSITION EXHIBIT 15
11:45 a.m.
BY MR. BURCHFIELD:
Q. And is Exhibit 15 your invoice for services rendered in connection with the June and September versions of your report here?
A. That is the invoice as of October 11 -- as October 1, yes.
Q. Okay. So that would include the June version and the September version?
A. Yes, it does.
Q. And the total number of hours you spent as of that time was?
A. 31.5.
Q. Okay. And do you recall, Dr. Daniels, how many more hours you have spent in connection with your addenda, which is Exhibit 7?
A. My recollection is less than ten.
Q. So all in for your reports in this matter you spent roughly 40 hours?
A. I think that's a good estimate.
Q. Have you -- have you invoiced Ms. Brault for your rebuttal report as of yet?
A. Not as of yet, no.
Q. And has the $8,000 fee been paid as of yet?

Page 75

A. It was -- yeah, 4300, because they had paid the retainer.
Q. Okay. I'm looking at the $8,000 figure in your report, but they're current on the invoices you've tendered?
A. Yes, they are.
Q. All right. Now let me look at -- let's look at attachment 2, which is on page 22 of Daniels Exhibit 6, and can you just confirm for the record that this is the list of materials that you have relied upon in connection -- in preparing your report, plus any additional materials cited in the footnotes of your report?
A. Yes, I believe this encompasses everything.
Q. Okay. Did you -- could you describe what if any literature search you did in preparing your report?
A. I did an extensive literature review in order to address the focus that I was asked to look at, and that would be the impact of changes in plan on the retirees. So I researched the current literature that's published and peer reviewed to find information in that area.
Q. And about how many hours did you spend on that extensive review?
A. It's listed in here. Three, four, five, roughly.

Page 76

Q. So March 31 and June 1 I see literature review entries totaling four hours. Is that it?
A. That's about right, yep.
Q. Okay. And you were satisfied that your literature review in that four hours was sufficient to render the opinions that you've rendered in this case?
A. Yes.
Q. Okay.
A. I have reviewed the literature in this area before.
Q. So obviously you relied upon your extensive experience as an economist in the health care area, you relied on your literature review you just described, you relied on the documents that are listed in attachment 2 of your report, and you relied upon letters submitted by the individual retirees.
Is there anything else that you have relied upon to form your opinions in this case?
A. I did not rely upon the letters from the retirees in the formation of my opinion.
Q. Okay. You cite them in your report. What -- how would you describe what you did with them, if you don't call that reliance?
A. Earlier on we talked about the report that was submitted in June --
Q. Um-hum.

Page 77

A. -- that mirrors this report. The difference really between the two is -- are the citations from the retiree letters, which served to provide real world examples of the cited research and my opinion.
Q. Okay. You wouldn't say that your report rises and falls on those retiree letters, would you?
A. As I just said, they were to provide real world examples, but my opinion was based on my experience and the literature.
Q. Did you find the retiree letters credible?
A. Found that the retiree letters were consistent with the literature, in my opinion.
Q. Yeah. We'll look at some of that in a minute.
Okay. So in terms of what you relied on for your opinion, your experience, the review of the literature, the review of the documents listed in attachment 2 to your report, anything else that you relied upon for purposes of forming your opinions in this case?
A. I do not believe so.
Q. Okay. You did not do any field work, I assume?
A. What do you mean by, "field work"?
Q. You didn't go out and personally interview any of the retirees?
A. No.

Page 78

Q. You did not do a formal survey of the retirees?
A. Clarify. Retirees meaning this group, or retirees --
Q. Fair point.
The plaintiff retirees. You did not do a survey of the plaintiff retirees?
A. No.
Q. You didn't do any econometric analysis on your own?
A. No. That would not fit within the scope of what I was asked to do.
Q. You didn't do any one-on-one interviews with retirees?
A. No.
Q. You didn't review any retiree financial information?
A. No.
Q. And you didn't do any comparison of the proposed CNH plan to any other health plans that are currently available in the marketplace?
A. I did not do any such comparisons.
Q. In your report on page 13 -- let's start on page -- yeah, on page 13. In the first -- in the second paragraph there you write, Based on my experience, industrial workers who for three to four decades were covered by an employer-sponsored, collectively-bargained group benefit plan, first as an active worker and then in retirement, generally have lower levels of health insurance literacy than nonindustrial

Page 79

retired workers who were not covered by a collective bargaining agreement.
Do you see that?
A. I do see that.
Q. And you stand by that statement?
A. That is my opinion.
Q. And what is that opinion based on, Dr. Daniels?
A. Based on my experience.
Q. And describe that experience for me.
Have you -- is it experience borne of talking to those retirees? Literature search? What is it based on?
A. It's based on my experience working with the plan sponsors who oftentimes have both workers -- employees that are covered by a collective bargaining agreement and those that are not.
Q. How do you make an assessment of the health insurance literacy of the covered individuals without having discussions with those covered individuals?
A. There's research and such, as I've noted later on when we talk about the Consumers Union study, where they have done that testing of health literacy.
Also worked on health literacy as part of a Robert Wood Johnson Foundation project that's listed on my resume.

Page 80

Q. And that's the Consumers Union study that's cited in footnote -- is it footnote 23 of your report on -- 22 of your report on page 12?
A. That is correct.
Q. Okay. And you say in paragraph F there, Retirees, when faced with numerous choices of Medicare Part D prescription drug plans, often make suboptimal selections. Medicare-eligible participants have a choice of over 30 Medicare Part D prescription drug plans in most states or CMS regions.
Do you see that?
A. Yes, I see that.
Q. And you stand by that statement?
A. Yes. There's literature that supports that.
Q. How many Medicare Part D plans are there available in the Wisconsin area?
A. I don't know specifically today.
Q. And when you say, Over 30 Medicare Part D prescription drug plans in most states, does that mean 30 per state, or does it mean 30 in aggregate?
A. Thirty per state.
The number's dropped a little recently, but I have not looked at Wisconsin currently.
Q. Have you looked at -- have you looked at Illinois?
A. No.

Page 81

Q. Or Iowa?
A. No. It's not relevant in my work.
Q. I'm sorry?
A. It's not an area of focus for me. This is individual products.
Q. You understand, don't you, that the manufacturing facilities at which these retirees worked were in those three states?
A. I -- yes, from the documents I reviewed.
Q. The next paragraph you wrote, A study published by the National Bureau of Economic Research of Medicare enrollees' selection of a Part D plan found that less than 10 percent of Medicare beneficiaries enrolled in what for them would be the most cost-effective plan, costing the retirees hundreds of dollars per year in avoidable, out-of-pocket expenses. This is significant for retirees on a fixed income as it limits what they have to spend on other necessities, such as health care, household expenses, et cetera.
Do you see that?
A. I see that.
Q. And you stand by that?
A. I do.
Q. And it sounds to me, Dr. Daniels, that you don't have a lot of confidence in the ability of

Page 82

union-represented, industrial retirees generally, or in this group of retirees, to make -- to make prudent, careful economic decisions on their own about their health care.

A. Based on the -- on the research I've cited and in my experience, it is my opinion that they are not well-equipped to make such decisions.

Q. You understand, don't you, that now, under the Affordable Care Act, the uninsured population is being asked to do exactly that by the Federal Government, right?

A. The under-64 uninsur -- population is being asked.

Q. Are you suggesting that people get a lot dumber when they turn 65?

A. I'm not suggesting that.

Q. Okay. Well, let me --

A. But certainly if you are 80 it would be more of a challenge.

Q. Well, is it -- are you -- do you draw material distinction between people under 65 and people over 65 in terms of their health care literacy?

A. There's some research that would support that there is a difference.

Q. And what research is that?

A. I can locate it for you, but it's been again through

Page 83

the Robert Wood Johnson Foundation work. We did look at some differences in health literacy, and it did vary by age.

And it's not because of intelligence; it's how long you've been used to a certain type of delivery mechanism for health care.

Q. Would you turn to page 15 of your report? And that's your signature there, right?

A. Yes.

Q. And there's no footnote on that page, but the last footnote in the report is on page 14, footnote 25. Do you see that?

A. I see that.

Q. And, Dr. Daniels, if we go through the report of those 25 footnotes, by my count 15 out of the 25 references in your report, cited references, are to the retiree letters. Does that sound right?

A. I did not count them.

Q. It is footnotes 3, 4, 5, 9, 10, 11, 14, 15, 16, 17, 18, 19, 21, 24, and 25. Does that sound right?

A. I believe so.

Q. Now, having just testified that the level of health care literacy among this very group of retirees is low, what weight are you putting on these retiree letters?

Page 84

A. None.

Q. None. Okay.

Do you know what information about the plans -- do you know what information about the proposed plan the retirees were given before they wrote those letters?

A. No.

Q. Did you ask?

MR. CANZANO: I'm going to object to the extent that involves communication with Counsel.

BY MR. BURCHFIELD:

Q. Well, would you agree with me, Dr. Daniels, that a letter written by a person who has no understanding of the proposed plan should carry no weight in this proceeding?

MR. CANZANO: I'm going to object to the extent it assumes facts not in evidence.

THE WITNESS: They have an understanding. There's a difference between understanding and being able to make the best decision.

BY MR. BURCHFIELD:

Q. And my question for you is: Before you cited 15 of those letters in your report, did you make any inquiry about what information the retirees were provided about the proposed plan?

Page 85

A. I don't recall specifically discussing that with Counsel.

Q. Do you, as you sit here right now, recall finding out any information they were given?

A. I don't recall.

Q. Do you know if they were given something -- given information in writing?

A. Based on reading the letters, it was apparent -- it seemed apparent that they were given something. They had knowledge of the proposed plan.

Q. Well, obviously feel free to disagree with this, Dr. Daniels, but having read the letters myself, it seemed to me that the retirees were told little more than that the health benefits they were going to get were going to be worse than the ones that they have.

Did you see anything in the letters that led you to believe that they had more specific information than that?

A. I would need to go back and look at them again, but I do seem to recall that they -- there were some that had a more -- had greater specificity.

Q. About the plan?

A. Correct.

Q. Do you recall a number of them -- well, do you know what the -- do you know how these letters originated?

Page 86

In other words, were they a spontaneous outcry by the retiree class, or were they requested in some way?
A. I assume that they were requested, given that they were addressed to Counsel.
Q. And do you know what -- do you know -- we have in the law what we refer to as leading questions. I've been known to ask some of those myself. But do you know if the request for information was done in such a way that might have prompted particular responses?
A. I have no knowledge.
Q. Would that matter to you as an expert in terms of whether to credit these letters or not?
A. I'd have to know more about it.
Q. But you didn't make any inquiry?
A. Again, I didn't rely on these letters.
Q. Do you find them reliable?
A. I find them consistent with the literature that I cited and my opinion.
Q. Well, standing alone do you find these letters supportive -- would you be comfortable relying on these letters as supportive of any conclusion?
A. Of any conclusion?
Q. Yeah, any conclusion. And I'm going to ask you what conclusion.
A. Yes.

Page 87

Q. What conclusion?
A. That retired -- the retiree letters expressed a concern that, if plan benefits were changed, that it would negatively impact them.
Q. Do you, Dr. Daniels, know how many -- there were -- let me start again.
We received in connection with your report, I believe the number was, 58 unique letters. Does that sound about right to you?
A. Sounds about right.
Q. And you relied on 15 of those letters?
A. I chose 15.
Q. You cited 15 of those letters?
A. I included 15.
Q. And how did you choose the 15 you decided to cite?
A. I chose them based on the ones that fit with the original draft report that I did and the topics that I had already laid out. There were some that were not as on topic or whatever.
Q. So you just --
A. I chose -- I selected a subset.
Q. You chose the ones that supported your opinion?
A. No.
Yes, they supported my opinion. There were others.

Page 88

Q. Were there some that didn't support your opinion?
A. Not that I recall.
Q. Do you know how -- you say in your report that there are --
A. What page?
Q. I'm on page 2.
You say that there are currently 2,037 non-Medicare-eligible participants and 1,982 Medicare-eligible participants.
Do you see that?
A. I do.
Q. And that's about 4,019 total participants in the plan, right?
A. That is correct.
Q. As a -- you've had training in econometrics, right?
A. A long time ago, yes.
Q. And statistics?
A. Yes.
Q. Would you consider the 58 letters that you've included to be a random sample?
A. I don't know enough about how the letters -- they requested the letters. I know from a sample size perspective it's valid.
Q. So 58 -- 58 observations out of 4,000 would be, in your estimation, if randomized, a sufficient sample?

Page 89

A. My past recollection of training and statistics is a sample size of 30 was good to go, was sufficient.
Q. And the margin of error varies significantly for a small sample size of that nature; is that correct?
A. The smaller the sample size, the lower the level of reliability.
Q. Did you find -- did you find it of any concern, Dr. Daniels, that you were provided only 58, if that is the number, but certainly less than a hundred letters, out of the 4,000 retirees?
A. I didn't have any reason to question the number of letters.
Q. Did you attend any of the meetings that the plaintiffs counsel had with the plaintiffs in East Moline, Burlington, or Kenosha?
MR. CANZANO: Object to assumes facts not in evidence and foundation.
THE WITNESS: No, I did not.
BY MR. BURCHFIELD:
Q. As I reviewed the letters, Dr. Daniels, none of them were under oath. Is that consistent with your recollection?
A. They're just retiree letters. I...
Q. Do you know if the -- if Plaintiffs' counsel received any letters from retirees that were not provided to

Page 90

you?
A. I'm not aware of any.
Q. Did you ask?
A. I asked for the letters. This is what I was given.
Q. As a professional economist what do you expect people to say if they're told they're going to have to pay more for something?
A. Generally they will not be happy about it.
MR. CANZANO: Is that question pay more for the same thing?
THE WITNESS: I assumed that.
BY MR. BURCHFIELD:
Q. Let me ask you to look at footnote 14, and you'll see reference in there to a letter from, I think, Ms. Blondell. The note 14 would be on page 9, and it's -- refers to the last quotation there on the page. Do you see that?
And the quotation is -- are you with me?
A. I'm just double-checking the comment.
Q. You see there the quotation is: Simply put, the financial impact of the extra cost would be overwhelming. I would just stop taking all medications and let nature take its course, unquote.
Do you see that?
A. I do see that.

Page 91

Q. Did you find that credible?
A. Yes.
Q. Okay. Let's look at footnote 21, which cites to a letter from a, I think, Mr. Michael Darin. Davis, you had. It appears to me like it might be Darin, but it does say Davis.
Are you on page 12, footnote 21?
A. I am.
Q. And there the quotation is in the second paragraph. It says, A plan participant writes, Any new expense will completely ruin me. If it comes down to that point, I plan to stop taking my medications and let nature take its course, unquote.
Do you see that?
A. I do.
Q. Does it sound to you a little suspicious that two independent retirees used that same terminology?
A. It's a -- no. It's a common term of saying, I'll just let nature take its course.
Q. I'll stop taking my medications and let nature take its course. That didn't strike you as a suspicious turn of phrase?
A. No, it didn't. It's not that atypical for people to say those types of things.
Q. Would you entertain a hypothesis that use of that

Page 92

terminology was as a result of a leading question or a comment that they might have heard?
A. I wouldn't know.
Q. Would it surprise you, or did you notice as you went through these letters, that there were a number of repetitive uses of particular phraseology in the 58 letters?
A. It did not strike me. I did not notice similar phraseology going through them, no.
Q. Would that be a concern to you, if it turned out to be the case, and if you had noticed it?
A. Not -- it would not be a concern if it's commonly-used phraseology.
Q. Do you recall any of the 58 letters providing complete financial information on the retiree's family?
A. Would you explain a little what -- you mean, like, their total income and assets and --
Q. Total pension income, total social security income, other income, assets.
A. I don't recall letters containing that type of information.
Q. Would that be relevant in evaluating the credibility of a retiree who is claiming that the increased cost would have a devastating impact and might lead them to discontinue all their prescriptions?

Page 93

A. I wasn't asked to evaluate. I didn't have income data.
Q. Well, but my question -- but I'm asking you now, and that is: Would you find it -- and maybe you wouldn't. Would you not find total income and total asset information about a person claiming that a particular event was going to have a devastating financial impact relevant to evaluating the credibility of that person?
A. In order to -- the information that would be required would be extensive; not just assets, liabilities. It also would be subjective, because what is devastating to that individual might not be devastating to you or I.
Q. But it would at least be relevant data to determine if someone's claim of complete ruin as a result of an increased health care cost was credible or not?
A. I don't think that it's totally true, because again, it's subjective. We may say it's not complete ruin; but if they view it that way, and they're not willing to continue to take their meds because they feel it's financially ruinsome (sic), and they may have obligations that don't show up on their own personal financial statements, they're either taking care of their -- like, a disabled child or grandchild or something -- I don't know that we can pass that

Page 94

judgment.
Q. We need more information than we've got from these letters to pass that judgment, don't we?
A. I don't know why you would want to pass that judgment.
Q. Well, to the degree it is relevant that the financial impact of these changes is devastating, don't we have to address that judgment?
A. Demonstrate it with the report prior to the letters that the retirees would be adversely impacted a number of different ways by the proposed changes.
MR. BURCHFIELD: I ask the reporter to mark as Daniels Exhibit 16 a copy of the decision of the United States Court of Appeals for the Sixth Circuit in Reese versus CNH America dated June 5 -- well, actually dated September 13, 2011.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 16
12:19 p.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, have you read this -- have you read this decision before?
A. Yes.
Q. And it's listed as one of the documents you rely upon in attachment 2 of your expert report, item number 4, correct?

Page 95

A. Yes.
Q. Let me ask you to look at page 6 of this document, and beginning in the first full paragraph there over to the last bullet point on page 7, would you please look at those, please, and just read into the record the aspect of that decision, the question in that decision, that your report is most directly addressing?
A. My report addresses the following --
Q. Okay. Go ahead. Shoot.
A. -- it provides a summary of what premiums, deductibles, and copayments most retirees pay under the old plan, question mark, under the new plan; as well as what differences, if any, is there between the quality of care available under the old and new plans; as well as what differences, if any, is there between the new plan and the plan CNH makes available to current employees and people retiring today.
Q. Okay. Anything else?
A. No.
Q. Can you -- let's look back at Exhibit 6, your report, and perhaps you can point me to the pages which address what premiums, deductibles, and copayments most retirees pay under the old plan, what about under the new plan.

Page 96

A. Refer to page 3.
Q. Yep.
A. In number 6, and they're outlined in A, B; continuing onto page 4, C, D, E; continuing onto page 5, we have F, G, which continues onto page 6.
Q. Okay.
A. And I stand corrected that what difference between the new plan -- plan makes available to current employees, doesn't quite do that directly.
Q. I'm sorry, say that again?
A. The third item I had cited, what differences are there between the new plan and the plan CNH makes available to current employees and people retiring today, it's not stated -- it's not written that way in my report, so...
Q. And then you also mention what difference is there in the quality of care available under the old and new plans.
A. I would say my entire -- from then on my report addresses quality of care, because a key element of quality of care is access to care, and that means affordable access. But specifically beginning on page 13, I do have a section that's just devoted to health care quality impacts of the proposed plan.
Q. We'll talk about that momentarily.

Page 97

All right. Anything else?
A. No.
MR. BURCHFIELD: Okay. Let me ask the reporter to mark -- ask the reporter to mark as Daniels Exhibit 17 an excerpt from Mr. Macey's report, pages 19 and 20 of Mr. Macey's report.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 17
12:26 p.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, I have provided you --
MR. CANZANO: I have pages 20 and 20.
MR. BURCHFIELD: Excuse me?
MR. CANZANO: I have pages 20 and 20.
MR. BURCHFIELD: Oh.
MR. HOCHUL: I'm sorry. This came out wrong.
BY MR. BURCHFIELD:
Q. Dr. Daniels, do you have pages 19 and 20?
A. I do indeed.
Q. Okay. Let's get our colleagues straightened out, and then we'll go forward.
Okay. This is pages 19 and 20 of Scott Macey's expert report in which he has, in chart form, made a comparison between the health care plan that

Page 98

retirees currently have and the proposed pre and -- pre-Medicare and Medicare-eligible participants, and my question for you on this is: Reviewing this chart, do you see anything on this chart that you disagree with as a mere recitation of what the prior plan -- what the existing plan and the proposed plan would do?

(Off the record at 12:29 p.m.)

(Back on the record at 12:29 p.m.)

THE WITNESS: Other than the premium numbers, contribution numbers, which vary from what -- the documents I relied on.

BY MR. BURCHFIELD:

Q. Can you be specific about what your -- what issues you were having?

A. Page 19.

Q. Right.

A. Proposed plan, pre-Medicare-eligible participants' monthly contributions. My report reflects -- and I'd have to go back to my documents to recall where, but $91 per month contribution beginning in 2013.

Q. And we know that didn't happen, right?

A. That's correct. And so that is not consistent.

And $10 per month for Medicare-eligible participants.

Q. Okay. Other than those two, is it consistent?

Page 99

A. With a bit of hesitation that by lumping copayments into one category when some things might have changed through coinsurance, at a high level this is consistent.

Q. Okay.

A. But not detailed enough to say that it's exact.

MR. BURCHFIELD: Let me ask the reporter to mark as Daniels Exhibit 18 the interrogatory responses of Jack Reese, and as Exhibit 19 the interrogatory responses of George Nowlin.

MARKED BY THE REPORTER:

DEPOSITION EXHIBITS 18 and 19

12:32 p.m.

BY MR. BURCHFIELD:

Q. Dr. Daniels, you have in front of you Exhibits 18 and 19, the interrogatory responses by Mr. Reese and Mr. Nowlin respectively; is that correct?

A. Yes.

Q. It's at the top of the second page who's answering them.

A. Yes.

Q. Okay. Have you seen these before?

A. No. I don't believe so.

Q. Let me ask you to look at page 3 of Exhibit 18, and under interrogatory number 14, if you skip down to the answer, it lists Mr. Reese's income. Do you see that under part B?

Page 100

A. Yes. I'm reading that, yes.

Q. Pension from CNH America in 2010 $21,684, pension from UAW Staff Retirement Plan $30,000 declining down to 25,000; social security disability in D 20,000, 29,000, 30,000; annuities $7,800, 7,250, 15,000 in 2010, 2011, and 2012 respectively.

Do you see that?

A. I see that.

Q. These numbers add up to something north of $80,000 a year of income for Mr. Reese. I'll ask you just to assume that.

In your -- in your opinion is Mr. Reese devastated by the changes that CNH is proposing?

A. I don't know based on this.

Q. You didn't see a letter from Mr. Reese, did you?

A. I don't recall.

Q. Okay. What would you need to know?

A. This is one side of ones balance sheet. There's also liabilities, health status.

Q. Let me ask you to look at the -- at page 6 under interrogatory number 18, and it says, If your answer to interrogatory number 12 is not an unqualified no, then provide the information demanded by interrogatories 13 through 17 for each member of the plaintiff class that you have been certified to represent.

Page 101

And just for your information, interrogatory number 12 simply asks if the -- Do you contend that your financial condition is relevant to whether CNH America's proposed changes to your health benefits are permitted under the standard articulated in Reese -- in the Reese decisions.

And then back to page 6, it says, If your answer to interrogatory 12 is not an unqualified no, then provide the information demanded by interrogatories 13 through 17 for each member of the plaintiff class that you have been certified to represent.

You with me so far?

A. Um-hum.

Q. And it says, Answer: Plaintiff objects to this interrogatory as unduly burdensome, unnecessarily invasive of the class members' privacy, and not likely to lead to admissible evidence. Notwithstanding the objection, Plaintiff Reese responds: I do not have this information.

Do you see that?

A. I see that.

Page 102

Q. If one were to make a serious conclusion about whether the class members individually are being devastated, ruined, I think one of the other terms used was wiped out by these changes, wouldn't one need -- wouldn't it be prudent for one to look at the financial information, assets, liabilities, and income, for the retirees on a one-by-one basis?
A. It would still be subjective to look at it one-on-one basis, because you and I may differ as to what would be devastating.
Q. Um-hum. But it would be a more informed decision even if subjective; would you agree?
A. Not over the whole population.
Over the whole group, is that what you're saying?
Q. I don't understand that answer.
A. Well, I'm trying to understand why you would do it individual by individual. This was a benefit that they were all entitled to.
Q. Wouldn't you agree that some of the retirees could be impacted differently than others?
A. Certainly, yes.
Q. And wouldn't it be important in that circumstance to evaluate them and their financial circumstances individually to see whether they're individually

Page 103

impacted differently?
A. But they're going to be impacted regardless of their means. But the extent of that impact is a point-in-time observation. You could look today and say someone looks like they're all set, they're in good shape. That could change tomorrow for them.
Q. So would you or would you not agree that a prudent person making a determination of whether the plaintiffs individually are being -- are being seriously impacted by the proposed changes would look at their financial background?
Or if you don't think that would be pertinent information for a prudent person to look at, you may say so.
A. I don't -- there are impacts beyond just looking at cost of the change in the plan. If the network changes, providers change. So you could look at it from a financial point of view, yes, that's one piece of it, but there's other pieces to the change.
Q. Let's focus on the financial impact, because as I read the 56 letters -- 58 letters -- that's what they were focusing on, and that's what your report focuses on to a large degree, financial --
A. I disagree.
Q. Let's focus on financial impact. We'll talk about

Page 104

health care outcomes after lunch.
Wouldn't you agree that, in order to evaluate the financial impact on the individuals of the class, it would be prudent to look at their financial situations?
A. If one felt that the financial aspect was critical, you could look at their financial status at a point in time, but knowing that is only a point-in-time assessment.
Q. We may all die tomorrow.
A. That's right.
Q. But you would consider -- you would consider it prudent to look at the financial information?
A. No. I said that you could look at it if what your focus is -- if your focus is on assessing a potential financial impact.
Q. That's the question. If we're interested in assessing the financial impact on the retirees, shouldn't we look at their financial information?
A. If you want to look at it individually, then yes.
Q. Okay. That's all I wanted to know. Thank you.
MR. BURCHFIELD: I tell you what, why don't we -- we're at probably a pretty good breaking point. Let me just ask -- let me just ask a couple questions, then we'll take a break for lunch, if that's okay.

Page 105

BY MR. BURCHFIELD:
Q. On Daniels Exhibit 19 -- do you see that? This is the interrogatory responses by George Nowlin. And do you see, Dr. Daniels, his income information on page 3, down at the bottom of the page?
A. Yes.
Q. Okay. And just so you know, if you look at the first page of Exhibit 19, the caption of the case, just to confirm, Jack Reese is the lead plaintiff in this case. Do you see that?
A. I see that.
Q. And you see George Nowlin is also one of the named class representatives in the case?
A. I see that.
MR. BURCHFIELD: Okay. All right. Let's take -- let's take, you know -- do you want to take -- I'll take as much as you want, but I could probably do 30 minutes if we can get through the cafeteria in that period of time.
MR. CANZANO: Actually, 30 minutes is fine.
MR. BURCHFIELD: Okay. We'll do our best to get through the line in the cafeteria in that period of time and be back, you know, quarter after one or so.
MR. CANZANO: Okay.

Page 106

MR. BURCHFIELD: If we're a little bit late, I apologize in advance, but it's only because we've gone through the line several times.
MR. CANZANO: The line gets kind of sparse on Fridays, though, actually.
(Recess taken at 12:43 p.m.)
(Back on the record at 1:27 p.m.)
BY MR. BURCHFIELD:
Q. Good afternoon, Dr. Daniels.
Do you find it credible that a retiree faced with a $10 copay would cease taking all medications?
A. It is possible, depending upon the financial status and other factors pertaining to that individual.
Q. Well, anything is possible.
What is -- what do you think the likelihood is that a $10 copay would cause an individual to stop taking essential medications?
A. Again, it depends on the individual.
MR. BURCHFIELD: Let me ask the reporter to mark as Daniels Exhibit 20 two pages from the Federal Register of January 24, 2013.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 20
1:29 p.m.

Page 107

MR. BURCHFIELD: And I'm one short on that one. May turn up eventually.
BY MR. BURCHFIELD:
Q. Dr. Daniels, this -- I've given you Daniels Exhibit 20. Do you have that in front of you?
A. Yes.
Q. If you'd look on Federal Register page -- volume 78, page 5183, which is the second page of this excerpt, you will see in the middle of the second page a chart entitled 2013 Poverty Guidelines for the 48 Contiguous States and the District of Columbia.
Do you see that?
A. I do.
Q. And as an economist do you have some familiarity with the federal guidelines to define poverty?
A. At a high level.
Q. You see here, do you not, for the 48 contiguous states and the District of Columbia the poverty level for a one-person household as of the most recent date is $11,490? Do you see that?
A. I do.
Q. And for a family of two the poverty guideline is $15,510. Do you see that?
A. I do.
Q. Do you know how those numbers compare to the pensions

Page 108

received by the class plaintiffs in this case?
A. I do not.
Q. Is it your -- do you have any understanding as to whether the pension payments received by the class plaintiffs here, plus whatever social security payments that they are getting from the government, exceed those figures?
A. I have no knowledge of their pension amounts.
Q. Okay.
A. Or their social security, for that matter.
Q. You are aware that -- you're familiar with the literature -- you're somewhat familiar, I assume, with the literature on the effect of cost-sharing on -- on the willingness of individuals to seek health care?
A. Yes.
Q. And you are aware that much, if not all, of that literature says that the effect is more acute on the poor than it is on people who are more -- who are in financially better shape than the poor?
A. There is an income effect.
Q. And if it were the case that the retiree and -- that the pension and social security incomes of the retirees in this class were above, and maybe substantially above, the poverty level, would that factor into whether they are likely to forego

Page 109

necessary medications, in your view?
A. Based on the literature, it's not just those at the poverty level that will --
Q. But that's one factor?
A. -- that will reduce. It's also -- depend upon income, as well as other factors. So you can be above the poverty level, have a low income, and still will be adversely impacted by increases in copays and other changes in the plan.
Q. But relative income is certainly a relevant factor, right?
A. At the individual level, yes.
Q. And we saw earlier that 11 percent, I think was the figure, of post-65 individuals are solely reliant upon Medicare for their health insurance.
Do you remember that?
A. The Kaiser report, although dated, stated that information that you shared, yes.
Q. Okay. It was 2007, so not that dated.
A. Well, yeah.
Q. Do you have an opinion on whether the retirees in this case, as a class, are poor?
A. I don't -- I was not asked to review pension data or income data, so I don't have knowledge of their financial status. I looked at this as a group.

Page 110

Q. As a group do you consider them poor?
A. As a group we know from the literature and my experience that there'll be a distribution. Some will be wealthier than others, some will be poorer than others.
Q. You've worked with the UAW in some capacity, I take it, for 25 or 30 years. You're familiar with the UAW?
A. There were years which I -- my work did not intersect at all with the UAW.
Q. But you're familiar with the UAW as an organization?
A. Yes.
Q. And you would agree with me, wouldn't you, that the UAW certainly tries to negotiate pension benefits for its retirees that keep them substantially above the poverty level?
A. They try. That does not mean they're always successful.
Q. Do you know if they were successful with regard to CNH?
A. I have no knowledge of their pension benefits.
MR. BURCHFIELD: Ask the reporter to mark as Daniels Exhibit 21 a document entitled Letter of Understanding.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 21

Page 111

1:35 p.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, do you have in front of you Exhibit 21?
A. Yes.
Q. This is a letter with the heading Letter of Understanding Re: National and State Health Insurance Initiatives.
It is, although I haven't copied the entire collective bargaining agreement, an attachment to the 1998 group insurance plan, as you see indicated in the upper, left-hand corner.
Have you seen this letter before?
A. I have not. It's kind of difficult to read on this paper, but...
Q. My eyesight was better in 1998 also.
Once you've had a chance to read it, would you let me know?
MR. BURCHFIELD: Here's another copy of that. It just turned up.
THE WITNESS: Okay. I've completed reading it.
BY MR. BURCHFIELD:
Q. Recognizing that you haven't seen this before, does this have any -- well, let me step back.
Since 1998 you would agree with me,

Page 112

wouldn't you, that there have been at least two noteworthy changes in federal health care programs, Medicare Part D and the Affordable Care Act?
A. Could you repeat the beginning of your sentence?
Q. Sure. You would agree with me that since 1998 there have been two noteworthy changes in federal health programs, Medicare Part D, and the Affordable Care Act?
A. I would agree that those are two of -- noteworthy changes.
Q. Any others you can think of?
A. Those are the most major ones.
Q. Any minor ones you can think of?
A. No, because they're mainly tweaks. We had Medicare part C for a while if you go back, things that didn't work out so well.
Q. Having now looked at this letter, does it have any effect one way or the other on the opinions you have ventured in this case?
A. No, it does not.
Q. I'm going to ask you to look at -- would you look at your report, Daniels Exhibit 6, note 2?
A. Page?
Q. And the text -- the text begins on paragraph 6, carries over to paragraph 7.

Page 113

A. What page are you at?
Q. Page 6 of your report, Exhibit 6, the September report. And let me just read it into the record.
Access to health insurance plays a key role in retirement decisions. A study found that 54 percent of those surveyed indicated that access to retiree health insurance was, quote, extremely important, unquote, and another 28 percent reported that it was, quote, very important, unquote. And then footnote 2.
Do you see that?
A. Yes, I do.
Q. And in footnote 2 you cited -- there you go -- high employment cite -- you cited a document from the Employee Benefits Research Institute in January 2013; is that correct?
A. That's correct.
MR. BURCHFIELD: Let me ask the reporter to mark that document as Daniels Exhibit 22.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 22
1:41 p.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, after you've had a chance to look at this, would you please let me know if this is, in

Page 114

fact, the survey that you cited in footnote 2 of your report?
A. Yes, this is the document.
Q. Now, this is a -- this is a survey, correct?
A. That is correct.
Q. They asked a number of people about what -- about, in figure 5, the impact of health insurance on their decision to retire.
Do you see that?
A. Correct, I see that.
Q. In looking at this document I did not see the actual questions that were asked. Did you happen to notice those?
A. No. This is a survey, though, that they routinely do on an annual basis, EBRI, and the methodology is telephone based. It's described on page 4.
Q. It says at the bottom of page 4, The HCS, the health confidence survey, was conducted between June 28 and July 20, 2012, through telephone interviews with 800 individuals ages 21 and older.
Do you see that?
A. Yes, I do.
Q. And given that we are -- given that the survey is asking questions about the relevance of various factors to a retirement decision, would it be

Page 115

pertinent to you to know what portion of the survey respondents were in their 20s as opposed to in their 50s?
A. Well, it's a statistically-valid survey with results, so they don't -- they're not asking -- it's not a survey of just those nearing retirement age.
Q. So it wouldn't be relevant to you to know that?
MR. CANZANO: Could you repeat the question?
THE WITNESS: Yeah, repeat the question.
BY MR. BURCHFIELD:
Q. It wouldn't be relevant to you, I take it, to know what percentage of the survey respondents were in their 20s as opposed to their 50s?
A. It would be.
And the survey, though, the document -- and without rereading the entire study, though -- they are people that have worked a number of years, as indicated by they've worked longer than they had expected. So this isn't someone in their 20s, if you're -- referring back to the tables.
Q. I'm not sure -- I'm not sure we're -- maybe we're talking past each other.
My question for you is: If there were an even distribution of people in their 20s, 30s, 40s,

Page 116

50s, and 60s, and the questions related to factors going into a retirement decision, would it bear on the credibility you've placed on the study to know that close to half of the survey respondents were 20 or more years away from retirement?
A. Well, if we refer back, this is focused on people that are closer to retirement, in my interpretation of this quickly, without going back.
Q. Where are you reading?
A. If we go back to figure 1.
Q. Right.
A. Let's see.
Q. Figure 1 is --
A. I'm sorry. I'm sorry.
Q. Figure 1 is sourced to something other than the survey on which you've relied.
A. I need to go back and refresh my memory, but the HCS is a survey that's focused on older workers and savings for retirement in general as well as this health care section. So it's not 20-year-olds.
Q. Well, you would agree that's not what it says. It says, The HCS was conducted between June 28 and July 20, 2012, through telephone interviews with 800 individuals, ages 21 and older.
MR. CANZANO: He's reading from right

Page 117

there.
THE WITNESS: Yeah. But you're correct.
BY MR. BURCHFIELD:
Q. And it doesn't give a margin of error for the survey that I saw.
A. No, it doesn't report that out.
Q. And it doesn't give a breakdown of what the demographic distribution of the survey respondents is that I saw.
MR. CANZANO: I'm going to object to that as mischaracterizing the document.
BY MR. BURCHFIELD:
Q. Do you see a demographic distribution of the survey respondents?
A. They didn't do a survey that was aimed at identifying differences by demographics.
Q. So I take it the answer to my question is: No, there is no demographic distribution of the 800 survey respondents here?
A. I can't assume that.
MR. CANZANO: I'm going to object to that. Mischaracterizing the document.
BY MR. BURCHFIELD:
Q. Okay. Let me ask you that.
Can you point me anywhere in this document

Page 118

that you cited in your report where it provides a demographic breakdown of the 800 people, ages 21 and older, that it surveyed from June 28 through July 20, 2012?
A. I do not see it in this document.
Q. So no margin of error stated, right?
A. Not in this report --
Q. Okay. No --
A. -- paper.
Q. No demographic breakdown, right?
A. Correct.
Q. No --
A. Based on this -- this is in a notes document and not necessarily the entire research brief.
Q. And no reiteration of the questions that were asked, right?
A. They are not contained in this document.
Q. Okay. You say, Not in this document.
Did you look at something other than this document?
A. No, I did not.
Q. So as you sit here today, you don't know whether that information is publicly available or not, right?
A. Which information?
Q. Margin of error, demographic distribution of the

Page 119

sample, or -- or the questions?
A. The information is likely available. Whether it's publicly available depends, because some of EBRI's work, the more detailed work, is provided to their member organizations and not all of it to the public.
Q. But you haven't seen it?
A. No. I did not review it as part of this work.
Q. Now, you know that there are empirical behavioral studies that try to address the issue of health insurance benefits and their effect on retirement. You know that, don't you?
A. I'm not familiar with behavioral studies.
Q. You haven't -- are you not aware of studies that --
A. I don't know what you mean by "behavioral."
Q. That -- let me rephrase the question.
Are you aware of any studies that, using actual human behavior reacting to changes in health care structures, evaluate the greater or lesser likelihood of retirement?
A. Not that come to mind. It's the ones I've cited in this paper.
Q. You're not familiar with the Gustman and Steinmeier study with the National Bureau of Economics Research in March 1993?
A. Quite candidly, when I did my literature review,

Page 120

documents, studies going back that far, are very dated.
Q. Okay. How about --
A. I try to find things more relev -- more current.
Q. How about David Blau and Donna Gilleskie, December of 2005, Health Insurance and Retirement of Married Couples, University of North Carolina Chapel Hill?
A. I don't believe that's one that I reviewed you were provided.
Q. How about Coe, Khan, and Rutledge, May 2013, Center for Retirement Research at Boston College?
A. I don't even know if these documents -- these are relevant to my work.
Q. But in any event, you didn't consider any of them?
A. No.
Q. The only source that you relied upon for your conclusion that health insurance -- that access to health insurance plays a key role in retirement decisions, the only external source you cite for that paragraph, is the EBRI survey that we talked about?
A. That and my experience.
Q. Okay. Let's talk about your experience.
What -- have you done any empirical analysis -- let me start more basically.
Have you done any published work on the

Page 121

effect of health care -- of access to health care insurance on retirement outcomes?
A. No.
Q. Have you done any -- have you done any empirical research on that, which is to say, comparison of the actual retirement decisions of people under one health care regime versus another health care regime?
A. I have not.
Q. Have you done any methodical surveys of persons within the range of retirement decision-making on that issue?
A. No.
Q. Have you conducted methodical meetings with potential retirees who are considering retirement?
A. From a research perspective?
Q. Yes.
A. No.
Q. What is your experience in this area, Dr. Daniels?
A. It ranges from work at the UAW, attending retiree meetings, pre-retiree meetings, continued work after the UAW at the Greater Detroit Area Health Council, which also then involved trust funds and others, and as health care costs continue to rise, there's much written about individuals wanting to continue to work because of the health care benefits, as well as to date we see it.

Page 122

Q. And others have studied those issues, but you haven't in a methodical way?
A. That's correct.
Q. Okay. By the way, Dr. Daniels, with regard to Daniels Exhibit 22, the EBRI survey, looking back at figure 5 on page 6, you would agree with me, wouldn't you, that, as that chart is constructed, it doesn't shed much light on whether the survey respondents were addressing a binary system, full health insurance, or no health insurance; or whether they were addressing the gradations of health insurance?
A. This uses the term health insurance as a single term.
Q. So that could be retire with health insurance or retire without health insurance, right?
A. That is correct.
Q. And here we know that the changes that are being made in the health program are not eliminating health insurance; they are simply increasing the cost-sharing, correct?
A. I disagree.
Q. How do you disagree?
A. You're eliminate -- the prescription drug benefit is eliminated under the proposed plan for the Medicare eligibles.
Q. But Medicare eligibles do have prescription drug

Page 123

coverage available to them through Medicare Part D, don't they?
A. Only if they elect to purchase such coverage.
Q. But it's available, right?
A. Well, certainly it's available, but it's eliminated.
Q. And you would agree with me that this survey, the survey results reported in table 5 of Exhibit 22, don't distinguish as to whether it's -- whether the retirees would pay for the program themselves or whether they would have it provided to them?
A. I don't think I'd go to that conclusion. I disagree.
Q. What --
A. It says they worked longer because they wanted to continue to have health care insurance through their employer.
Q. Based on that chart, do you draw conclusions about whether the persons being surveyed there were taking into account the potential availability of Medicare Part D?
A. I can't draw a conclusion such as that. There's not sufficient detail.
MR. BURCHFIELD: Let me ask the reporter to mark as Daniels Exhibit 23 a document entitled A Preliminary Expert Report of Suzanne Paran --
THE WITNESS: Paranjpe.

Page 124

MR. BURCHFIELD: -- Paranjpe, dated June 27, 2011.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 23
2:00 p.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, do you recognize Exhibit 23 as an expert report that you submitted in the case of Thomas Temme and Shirley Temme, individually and as representative of a class, versus Bemis Company, on or about June 27, 2011?
A. Yes.
Q. And is the -- is that your signature on the last page, page 4 of the document?
A. Yes.
Q. And at that point this -- the Suzanne Par --
A. Paranjpe.
Q. -- Paranjpe, Ph.D., is the person we now know as Dr. Suzanne M. Daniels, Ph.D., correct?
A. That is correct.
Q. Okay. Great. Just to be clear.
Let me ask you to look, please, on page 3 of that document. Just above The Facts Considered there's a paragraph that says, It is my opinion that an appropriate, alternative approach is to adjust the

Page 125

1985 annual $50 individual and $100 family deductibles by the consumer price index medical care for the period 1982 to 2011. This adjustment results in 2011 annual deductibles of $175.94 for an individual and $351.88 for a family.
Do you see that?
A. Yes.
Q. And that was your opinion in the Bemis case?
A. Yes.
Q. The --
MR. CANZANO: Just for the record, it's 1985, not 1982.
MR. BURCHFIELD: Okay. If I said '82, I misspoke. Should be '85.
BY MR. BURCHFIELD:
Q. Would you consider the difference in the family and individual deductibles -- or I should say: Would you consider the difference between the individual and the family deductibles that you thought appropriate in that case, of $175.95 for an individual and $351.88 for a family, to be materially different than the $200 deductible and the -- individual and the $400 family deductible proposed by CNH in this case?
A. Numerically they're similar amounts.
Q. Okay. And is it your view that the -- that a $200

Page 126

individual deductible and a $400 family deductible are oppressive or inappropriate in some way in relation to the deductible stated in -- that you advocated in the Bemis case?

A. The Bemis case was focused, my work, on a reasonable, commensurate deductible. It's not the focus -- the question I was asked, for this work that I've done.

Q. Would you agree that a $200 individual deductible and a $400 family deductible is reasonably commensurate?

MR. CANZANO: I'm going to object, because that's not the scope of her report, in that she wasn't asked to give an opinion on that.

BY MR. BURCHFIELD:

Q. If you don't have an opinion, you don't have an opinion, but I'm asking.

A. I don't have an opinion in this case.

Q. Okay.

MR. BURCHFIELD: Let me ask the reporter to mark as Daniels Exhibit 24 an opinion dated November 30, 2012, by Suzanne Paranjpe -- and I'm probably mispronouncing it, and I apologize -- and another opinion dated February 15, 2013.

MARKED BY THE REPORTER:
DEPOSITION EXHIBITS 24 and 25
2:06 p.m.

Page 127

BY MR. BURCHFIELD:

Q. Dr. Daniels, my only question for you about Exhibit 24 is: Do you recognize this as an expert declaration that you provided on or about November 30, 2012, in a case involving TRW Automotive?

A. Yes.

Q. And similarly with regard to Daniels Exhibit 25, do you recognize that as an opinion you gave in a case involving TRW Automotive on or about February 15, 2013?

A. Yes.

Q. Can you briefly describe the dispute in the UAW TRW case that you addressed in these two opinions?

A. I can address the change in plan design.

Q. What was that?

A. That the group retiree benefit coverage plan was terminated, and the retirees were given contributions into a health reimbursement account that varied just depending on the case of it. They could then use those funds to purchase individual Medicare coverage if they went through Extend Health, a broker that would help them select a plan. In some cases out-of-pocket expenses could also be reimbursed, if eligible, through the health reimbursement account.

Q. And did that case involve only retirees 65 and older who were Medicare eligible?

A. That is my recollection.

Q. Okay.

A. Yes, for Daniels 25, yes for both.

Q. And are these -- both of these -- are both of these opinions, 24 and 25, from the same case, or are they different cases?

A. Just think for one second.

They're separate legal actions against TRW. They're different groups.

Q. Okay. And if you don't recall, just say so, but do you remember what the distinguishing characteristics of the two groups are in one case versus the other?

A. I don't -- there's some var -- I don't exactly remember, but there was some variation in benefits and contributions. But I don't recall with this one.

Q. Okay. Let's now turn back to Daniels Exhibit 7, which is your rebuttal report or your addendum, if we could. Do you have that in front of you?

A. I do.

Q. And in that report you are responding to Mr. Macey's report to the degree it relies upon a Robert Wood Johnson report by Katherine Swartz entitled Cost-sharing: Effects on Spending and Outcomes; is that correct?

Page 129

A. I -- this is in response to his section 2B3 of his report.

Q. Okay. And you discuss in here, don't you, Dr. Swartz' paper?

A. I do.

Q. Well, I see it, I just can't get it out of the box.

MR. BURCHFIELD: Let me ask the reporter to mark that paper as Daniels Exhibit 26.

MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 26
2:13 p.m.

BY MR. BURCHFIELD:

Q. Dr. Daniels, do you recognize Daniels Exhibit 26 as the -- as the Cost-sharing: Effects on Spending and Outcomes paper by Dr. Katherine Swartz that you discussed in your rebuttal report, Daniels Exhibit 7?

A. Yes.

Q. And did you -- I take it that the only source that you have relied upon -- or let me start again.

The only source you have cited in your December 16, 2013, report, Daniels Exhibit 7, is the Swartz paper.

A. That is correct.

Q. Okay. Now, am I correct that Dr. Swartz relied in some measure on the Rand Health Insurance Experiment,

Page 130

which was designed between 1970 and 1974, and conducted between 1975 and 1978?

A. This work by Swartz is a survey of the literature, in essence, and not a study that would you cite something to rely on, but rather to really summarize the landscape of work that's been done in the field.

Q. Okay. I'll try to find it.

Let me ask you to look at the page of Daniels Exhibit 26 which has the last three digits at the bottom, right-hand corner 923 -- oh, I'm sorry, it's the page with the heading Methodology Overview.

Are you with me?

A. I am.

Q. And it says -- it is page 7. I see that now. It's -- in the first paragraph there it says, The rapid changes in medical care, along with changes in health insurance cost-sharing provisions, make studies done before 1990 less relevant for this review. Because it is so expensive to conduct a large, randomized experiment such as the Rand -- that's R-a-n-d -- Health Insurance Experiment, no experiments with variations in health insurance design have been conducted since the HIE, the health insurance experiment.

Do you agree with that statement?

Page 131

A. That -- I agree that experiments have not been conducted, and the key word is experiments.

Q. Okay. And then she goes on to talk about some of the studies and says, in the second paragraph, Unfortunately, many of the empirical studies of the effects of patient cost-sharing are based on cross-sectional data, which are collected at only one point in time. The problem with using cross-sectional data to analyze the effects of cost-sharing is that individuals often have some choice about the type of health insurance they have, and the choice of cost-sharing requirements could be driven in part by how healthy a person is or how much care the person expects to use. In this case, it is hard to disentangle the effect of cost-sharing from the effect of, say, the individual's health.

Do you see that?

A. Yes.

Q. And do you agree with her statement there?

A. It's difficult. Does not mean impossible.

Q. Okay. Would you look at page 10, please, under the heading Findings? And in the first bolded finding there it says, Reductions in patient-initiated care in response to increases in cost-sharing are likely to come predominantly from the half of the population who have low medical expenses, people who most likely are healthy.

Do you see that?

A. Yes.

Q. And do you agree with that?

A. Yes. In the context of the population that she's looking at for this report, yes.

Q. And what is your understanding of the population she's looking at here?

A. Her focus of this work is on the -- those under -- the non-Medicare eligibles that are covered under Health Care Reform under the ACA. That's her stated purpose in the introduction.

Q. Let me ask you to look at the bottom of page 11, and the bolded heading says, What of the effects of increased cost-sharing on health outcomes.

And it says, There has not been a study on the effects of increased cost-sharing on the health of a general population since the Rand HIE.

Do you agree with that?

A. Yes.

Q. And then she goes on to say -- at the end of that paragraph she says, As noted above, however, the HIE found that people with higher cost-sharing reduced their use of both appropriate and inappropriate health care services about equally. One hypothesis from this finding is that any negative effects due to reducing appropriate health care were matched by reducing inappropriate care that sometimes causes adverse health effects leading to hospitalizations.

Do you see that?

A. Yes.

Q. And I take it you mention -- you mentioned earlier the Dartmouth Atlas study which talked about overprescription and overutilization. Do you remember that?

A. Variations in care.

Q. And you would agree with me, wouldn't you, that to the degree there is a reduction in usage as a result of cost-sharing, some of that reduction could be reduced overutilization, which can have adverse health effects on the patients?

A. It could have -- it could address overutilization of those adverse things.

Just to clarify, though, the Dartmouth Atlas isn't as focused on drug overuse as medical procedures.

But on the other hand, cost-sharing, as in this last sentence you read, clearly if someone doesn't seek the appropriate care, it can result in

Page 132

Page 133

Page 134

greater costs and increased hospitalizations. And that's the point she is making. And which continues, the adverse effects of cost-sharing, onto the next page in her findings.

Q. But let's stay on this point for a second.

As I understand what she's saying in that last sentence on page 11, she is saying that there could be some reduction of necessary beneficial care with adverse health outcomes, but there may also be some reduction of unnecessary care which would have had an adverse health effect; and, she further suggests, those two effects might have a tendency to balance each other out.

Is that not the way you read it?

A. Balancing it out in terms of measuring in terms of saying inappropriate and appropriate doesn't balance it out for the individual involved.

Q. Let me just ask this question: What -- is there -- am I correct that other than Dr. Swartz' survey of the literature here, Exhibit 26, none of the reports that you have submitted in this case cite any authority on the issue of health effects of cost-sharing?

A. That is not correct.

Q. What other sources do you cite for adverse effects of cost-sharing?

Page 135

A. Page 9.

Q. You're on Exhibit 6?

A. Yes. A and B.

Q. And I see what you're pointing to, Dr. Daniels, but as I read those paragraphs, and I think I scanned those studies, my recollection is that they talked about the use -- patient's use of medications because of costs in paragraph A, but they did not evaluate the health outcomes as a result of that use -- of that reduced use of medications. Do you read it differently?

A. There's a difference between short-term and long-term health outcomes.

Q. I understand.

But do you understand those -- the study cited there in footnote 12, the JAMA study, do you recall that that study addressed either short- or long-term health consequences --

A. I believe it did.

Q. -- of the...

A. Sorry.

Q. Okay. You believe it did?

A. My recollection is that it did.

Q. Okay. And do you recall, as you sit here, what the quantification of those adverse health outcomes was?

A. I don't recall the quantification.

Page 136

Q. And same issue with regard to paragraph B. The New England Journal of Medicine study suggested that copayments resulted in foregoing necessary outpatient care, leading to increased use of hospital care, but it doesn't -- that doesn't seem to me to address a health outcome.

A. When you think about something that could have been treated on an outpatient basis, the individual ends up not seeking the care due to costs, they end up in the hospital, it's a higher level intensity of service, means that they're not as well-off health-wise.

Does it go to the end point, based on this extract here, of did they die? In some cases, maybe; some cases, maybe not.

But it is an issue -- I mean, it is true with -- that, when you move to a higher intensity of care, it's because of your health needs being greater. So there is an adverse effect on ones health.

Q. Do you know if the -- if the New England Journal of Medicine study and the JAMA study were reviewed in Dr. Swartz' article?

A. I'd have to go back and cross-match it, but she had similar findings that she reported in her study, as I noted in my report.

Q. Okay. If you look at Daniels Exhibit 26, on page 33

Page 137

is the citation of the sources. Source number 127 seems to be, does it not, The Journal of the American Medical Association piece by Tseng, CW Tseng?

A. Yes.

Q. T-s-e-n-g?

A. Yes.

Q. Do you understand my question? My question is --

A. I said, I believe so.

Q. Thank you. I did not hear your answer.

And then the study referred to in subparagraph B, is that entry number 125 in Dr. Swartz' appendix?

A. I would need to confirm that with my files.

We did provide you all the actual -- we can pull that and double-check it.

Q. Um-hum. Okay. Let me ask you to look at the Swartz -- in the Swartz article, Daniels Exhibit Number 26, first at page -- on page 9 just above the last bold heading, and the sentence right above that heading says, The newly-released rules for health insurance plans created by the PPACA eliminate cost-sharing for four sets of preventive services, and Medicare also will no longer face cost-sharing for most preventive services as of January 2011.

Do you see that?

Page 138

A. No.
Q. I'm on page -- actually I'm on page 18. I'm sorry. I was looking at the footnote number. I apologize.
A. Okay.
Q. It's the -- I'm having a hard time reading these numbers. Maybe it's 16. It's the page with footnote nine at the bottom, whatever that is.
MR. CANZANO: Yeah.
BY MR. BURCHFIELD:
Q. Okay. Are you with me?
A. Now, yes.
Q. It says -- at the last sentence before the bottom heading, says, The newly-released rules for health insurance plans created by the PPACA eliminate cost-sharing for four sets of preventive services, and Medicare also will no longer face cost-sharing for most preventive services as of January 2011.
Do you see that?
A. I do.
Q. Is that accurate, so far as you know?
A. Yes.
Q. And then over on page 21, under the heading Findings, and this refers to -- let me just read the entire paragraph. It says, Schneeweiss and Zhang specifically examined the effect of Medicare Part D

Page 139

coverage gap on the use and out-of-pocket spending of beneficiaries who reached the coverage gap.
And, Dr. Daniels, you understand that to mean the doughnut hole?
A. Yes.
Q. Okay. Using different data sets, both studies found that people who reached the coverage gap reduced their use of drugs in the months after they were affected by the gap. Zhang, et al, estimated such beneficiaries reduced their drug use by 14 percent, 0.7 prescriptions per month, and Schneeweiss estimated that their use of drugs in four drug classes of the study declined at the rate of 4.8 percent to 6.3 percent per month after they reached the gap. Zhang, et al, also had data on people who had coverage for generic drugs in the coverage gap. Some of these people switched from brand name to generic drugs, but in general these people reduced the number of their prescriptions by only 0.14 prescriptions per month.
Do you see that?
A. I do.
Q. And do you know, Dr. Daniels, whether in the CNH plan the so-called doughnut hole is reduced as a result of the out-of-pocket annual maximums?
A. I'm not following you as far as the -- a doughnut hole

Page 140

in the CNH plan.
Q. Under Medicare Part D which the CNH -- which the retirees in this case would be able to avail themselves under the proposed plan, do you know if there is doughnut hole protection, if you will, as a result of the limit on out-of-pocket spending per year?
A. Typically not.
Q. Do you know in this plan one way or the other?
A. It would not -- under this plan the drug benefit is no longer part of the medical plan benefit. Its individuals are being, under the proposed plan, asked to go to the private marketplace if they want drug coverage. There's no integration done of the out of pockets.
Q. Let me ask you to look at the -- at the heading -- the last heading there on page 21, the last finding. It says, Long-term health effects of reduced use of essential drugs, especially for people with chronic health conditions, are unknown.
A. I would -- it's stated there, yes.
Q. Pardon me?
A. Yes.
Q. Okay. Are you aware of any -- of any studies to the contrary?

Page 141

A. Actually, Swartz on page 12 discusses other studies with other results relating to cost-sharing of prescription drugs.
Q. I understand.
A. And page 12 would show an adverse effect, the last sentence -- last two sentences on that page in particular.
And arguably the Goldman study as well.
Q. Okay. But having discussed all the literature, her finding is that: Long-term health effects of reduced use of essential drugs, especially for people with chronic health conditions, are unknown.
Do you agree that's her finding on page 21?
A. I would refer back and would suggest that it's her conclusions that are critical. And she has findings in two sections, so I don't know how one can determine that findings are findings. They're not findings.
MR. BURCHFIELD: Okay. Why don't we take about maybe five minutes. Let me review my notes. I think I'm pretty close to being done.
MR. CANZANO: Okay.
(Recess taken at 2:42 p.m.)
(Back on the record at 2:51 p.m.)
BY MR. BURCHFIELD:
Q. Dr. Daniels, can we turn to your -- to Daniels Exhibit

Page 142

6, your September report? And I'm on page 7, paragraph 9.
A. Yes.
Q. In paragraph 9 you say that, In my experience, and based on published research, retirees who are generally on fixed incomes are not able to afford even small increases in their expenses without hardship.
And it continues, and then -- and then you get to the next paragraph, says, A recent published study asked retirees about their ability to pay for a $2,000 unanticipated expense should it occur in the next month. The study found that only 50 percent of workers and 52 percent of retirees surveyed stated that they would definitely have $2,000 to cover the expense.
And then it says, Another published study found that 40 percent of retiree households had expenses that exceed their income, and over 14 percent of retiree households had spending that exceeded 75 percent of their income.
You followed all that?
A. I did.
Q. The study cited there in footnote 6, that's a survey, right?
A. That is correct.

Page 143

Q. And do you know, Dr. Daniels, what the income distribution of the persons surveyed in that study was?
A. I don't recall.
Q. Do you -- do you know if that study -- and I thought I had it here, but I don't.
Do you recall whether that study reported the questions that were asked?
A. My recollection is that the questions are not reported, typical for a study. The questions are not reported publicly.
Q. Do you distinguish between a study and a survey?
A. No.
Q. And then it says, Another published study found that 40 percent of retiree households had expenses that exceed their income, and over 14 percent of retiree households had spending that exceeded 75 percent of their income.
Do you recall whether that was a survey or an analysis of the actual finances of the respondents?
A. If I recall correctly, it is a survey as well.
Q. Okay. And again, do you know the income -- the income distribution of the respondents to that survey?
A. I don't recall today.
Q. Would you agree with me that at least conceptually a higher-income group would be less susceptible to the -- to small increases in expenses?
A. I take exception. I disagree, given the terminology you used, income, because income does not take into account ones debts, or ones liabilities, in other words, so it's disposable income. The difference between, as you know, income and your debts, that is of relevance.
Q. Point taken.
But wouldn't you expect that people, as the income increases, the ability of individuals to withstand an increase in their expenses increases?
A. Again I go back to saying: It's based on disposable income.
Q. And we just don't have any data on this class of retirees to know what their average disposable income is, do we?
A. I am not aware of any such data. I was not provided that information if it's available. I don't know.
MR. BURCHFIELD: Okay. That's all I have. Thank you very much for your patience.
Counsel, any questions?
MR. CANZANO: Just let me take a couple minutes. I don't think I have anything.
MR. BURCHFIELD: Okay.

Page 145

(Recess taken at 2:56 p.m.)
(Back on the record at 2:59 p.m.)
MR. CANZANO: We're going to reserve the right to read and sign.
(Deposition concluded at 2:59 p.m. Signature of the witness was requested.)

JACK REESE, FRANCES ELAINE PIDDE, JAMES CICHANOFSKY, ROGER MILLER, and GEORGE NOWLIN,

Plaintiffs,

vs. Case No. 2:04-cv-70592-PJD-PJK
Hon. Patrick J. Duggan, U.S.D.J.
Hon. Paul J. Komives, U.S. Mag. J.

CNH GLOBAL N.V. and CNH AMERICA LLC,

Defendants.

VERIFICATION OF DEPONENT

I, having read the foregoing deposition consisting of my testimony at the aforementioned time and place, do hereby attest to the correctness and truthfulness of the transcript.

_____
SUZANNE MARIE DANIELS, Ph.D.
Dated:

ERRATA SHEET

PAGE	LINE	READS	PAGE	LINE	SHOULD READ

_____
SUZANNE MARIE DANIELS, Ph.D.
Dated:

CERTIFICATE

STATE OF MICHIGAN
COUNTY OF OAKLAND

I, Mary Jo Power, a Notary Public in and for the above county and state, do hereby certify that this deposition was taken before me at the time and place hereinbefore set forth; that the witness was by me first duly sworn to testify to the truth; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related, nor of counsel to either party, nor interested in the event of this cause.

_____
Mary Jo Power, CSR-1404
Notary Public
Oakland County, Michigan
My commission expires: December 12, 2018